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Integrating sexual health services:

**An ethnographically-informed study of
attendee experience.**

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**Doctor of Philosophy
University of Edinburgh
2017**

Declaration

I hereby declare that:

- This thesis has been composed solely by myself.
- The work presented in this thesis is my own.
- This work has not been submitted for any other degree or professional qualification.

Sarah Elizabeth Jeavons Wright, August 2016

Abstract

Across the UK the integration of historically divergent specialities of genitourinary medicine (GUM) and well-woman/family planning (WW/FP) has emerged as a modern approach to sexual and reproductive health care provision. Integration's most visible form is the 'one-stop shop' (OSS), where a full range of services are brought together under one roof and wherein care is provided by comprehensively trained practitioners. To date, there exists only limited insights into stakeholder experiences of integrated clinics. Conducting ethnographically-informed research at one such purpose-built OSS over a 9 month period (2013-2014), I sought to redress this gap in knowledge. Accompanying 29 attendees along their journey through the clinic, my research offers a detailed examination of the extent to which experience is shaped by integration. Drawing upon literature at the confluence of medical sociology, social geography, and anthropology, including Gesler's (1992) 'geographic metaphor' of the 'therapeutic landscape', the thesis puts forward two key arguments.

First, I suggest that participants often reconstructed the clinic as aligned to their presenting need, for example, a 'GUM clinic', or a 'family planning' service. This finding, teased out over the course of the thesis, destabilises assumptions present in previous studies that integration be inevitably deterministic in shaping attendees' experiences. Second, the thesis contributes to a gaps in literature relating to Gesler's (1992) 'therapeutic landscapes' in three key ways. The first contribution is to show how affective landscapes *matter*, are significant, in the formation of experience in a novel setting – a transient, 'walk-in' clinic. The findings, further, point to the elevated import of the physical and symbolic landscapes in the case of the OSS - a place where there is little opportunity to cultivate therapeutic social relationships. Finally, the thesis speaks to the ways in which the affective landscapes of the clinic work to challenge, confirm or reshape attendees' preconceptions and expectations of sexual health services.

Together, these findings contribute to pre-existing accounts of the experience of integrated services by asking us to consider the influence of forces other than the integrated status of service delivery on attendee experiences of such sites. I argue that place should not be conceived as immutable but, rather, is subject to individual interpretations that are, themselves, the product of both situated and external contexts

Lay Summary

Since GUM and FP services were established in the UK, getting contraception or being tested for sexually transmitted infections or HIV would often mean attending either a ‘family planning’ clinic or a separate testing facility known as a ‘GUM’ clinic. Recently, however, there has been a change in the delivery of these services, with family planning and testing services increasingly being provided at the same clinic. This change is called ‘integration’, and has resulted in new clinics offering a wide range of sexual and reproductive healthcare services to those who attend in the hope that it will make it easier for people to quickly get the care they need.

So far, however, there is not much research about how people experience going to these new integrated clinics. This PhD focused on asking people attending one of these clinics about their experiences, by spending time with them as they waited for their time with the doctor or nurse. I spent nine months going to the clinic, and spent time with 29 attendees. These 29 people included 16 who came to the ‘walk-in’ service and 13 who had booked appointments for contraception.

My research found that most of the participants in my research did not recognise that the clinic was a new, ‘integrated’ clinic. Instead, they often spoke about it being a ‘GUM’ clinic, an ‘STI clinic’ or a ‘family planning’ clinic, not seeing the difference between old and new forms of service delivery. For a few people who did recognise that the clinic was different, this was understood positively. For example, to be offered all of the care they needed in one consultation, rather than having to go to a second facility, was regarded as a benefit, this suggesting that integration might not be as much of a problem for people as was feared by, both, advocates and opponents to integrated care.

Second, my research found that people did notice the atmosphere of the facility, and this impacted on their experiences. What the clinic looked like outside and inside, who the other people attending were, and the way the staff spoke to them were all influential in experience. So, despite attendees usually only spending a few hours at the clinic, the atmosphere mattered to people I spoke to.

Third, my findings show that experiences of the facility were influenced by forces external to the facility itself, in particular, ideas about personal responsibility and stigma linked to

reproductive control and sexually transmitted infection. Attendees saw themselves as having a pressing need to get treatment for an STI or to get time-sensitive contraception. As a result, attendees were generally grateful in their interactions with staff members. I argue that this was because they wanted to achieve a desired outcome – to ‘get in and get out’ - quickly and, often, without friends or family knowing about their visit.

The findings of my research suggest that people’s experiences of this new type of facility are linked to considerations beyond that of its integrated status.

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Undertaking my PhD has been a challenging, exciting and transformative journey. I look back on who I was when I arrived to the department and recognise the changes that have occurred in me as a result of this experience. Throughout, my growth has been supported and encouraged by supervisors, friends and family, to each of whom I would like to extend my sincere thanks and gratitude.

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List of Abbreviations used

BA – Booked appointment care pathway

BME – Black and Minority Ethnic

CSW – Clinical support worker

CT – Chlamydia infection

Cu-IUD – Copper bearing intrauterine device

GC – Gonorrhoea infection

GUM – Genitourinary medicine

HCP – Healthcare professional

ISRH - Integrated sexual and reproductive healthcare facility

IUC – Intrauterine contraception

LARC – Long-acting reversible contraception

LNG-IUS – Levonorgestrel-releasing intrauterine system (Mirena®)

MSM – Men who have sex with men

NTT – ‘No-talk testing’

OSS – ‘One-stop shop’

PEP – Post-exposure prophylaxis

SRH – Sexual and reproductive health, formerly ‘family planning’

WI – ‘Walk-in’ care pathway

1. Introduction



Chalmers Hospital, late 19th century (LHSA, 2014)



Chalmers Health Centre (Architecture and Design Scotland, n.d)

Occupying a small piece of land where two city streets meet sits a Victorian building with a rich history of providing healthcare to Edinburgh's population. Opened as an infirmary in 1864 (LHSA; Sproat 2009: 72), the facility has seen many renovations and expansions, including being requisitioned by the government for civilian and service personnel casualties of World War II (LSHA). In 1948, following the end of the war and with the birth of the NHS, the hospital was once again opened to the public (LSHA). Over the coming decades, the hospital continued to deliver inpatient and outpatient care, such as TB nursing clinics, GP services, physiotherapy and x-ray departments ('Dates of interest', 1964 - 1974) to the local population, while also serving as an annexe of the Hospital for Diseases of Women, located nearby. In 2009, the doors to the facility were closed as the hospital underwent a re-provisioning that would see it transformed into a purpose-built, fully integrated 'one-stop shop' (OSS) sexual and reproductive healthcare facility. In June 2011, the new service opened to the public.

1.1 Introduction

This thesis tells the story of attendees' experiences of their visit to this facility. The research, conducted using ethnographically-informed methods adapted to the field, provides detailed insights into attendees' experiences during their time at, and immediately having left, the facility. Advertised as a centre studentship, financed by a Doctoral Training Grant from the Medical Research Council, the research was supported by the local health authority and senior management at the facility. The position allowed me to design the study, which might be

conceived of as a ‘post-occupation evaluation’ (Curtis et al 2007), concerned particularly with examining, in real-time and in-depth, the experiential impact of the relationships established at the facility between people (interactions) as well as between people and things (Street and Coleman 2012: 10). In addition to these interactions, my ‘field of research’ included considerations of the ‘therapeutic landscapes’ (Gesler 1992) that comprise the facility, and the policies at play, acquired through interviews, observations and reading of grey literatures (Hansen 1997: 88).

The findings represented¹ in this thesis are the product of the time I spent at the facility in question, interacting with participants and observing the rhythms of the particular place. That said, and in keeping with the understanding that the modern clinic is no longer an ‘island’, cut off and isolated from wider society, but a reflection and reinforcing site within dominant social and cultural practices (Street and Coleman 2012; Long et al 2008; van der Geest and Finkler 2004), this thesis links the accounts from within the facility to broader debates. Informed by literatures located at the confluence of medical sociology, social geography, and anthropology, including Gesler’s (1992) ‘geographic metaphor’ of the ‘therapeutic landscape’, this research crosses disciplinary boundaries as it contributes new insights into the experience of integrated services, while adding to academic literature which seeks to understand and illuminate the political and social construction of experiences in everyday life.

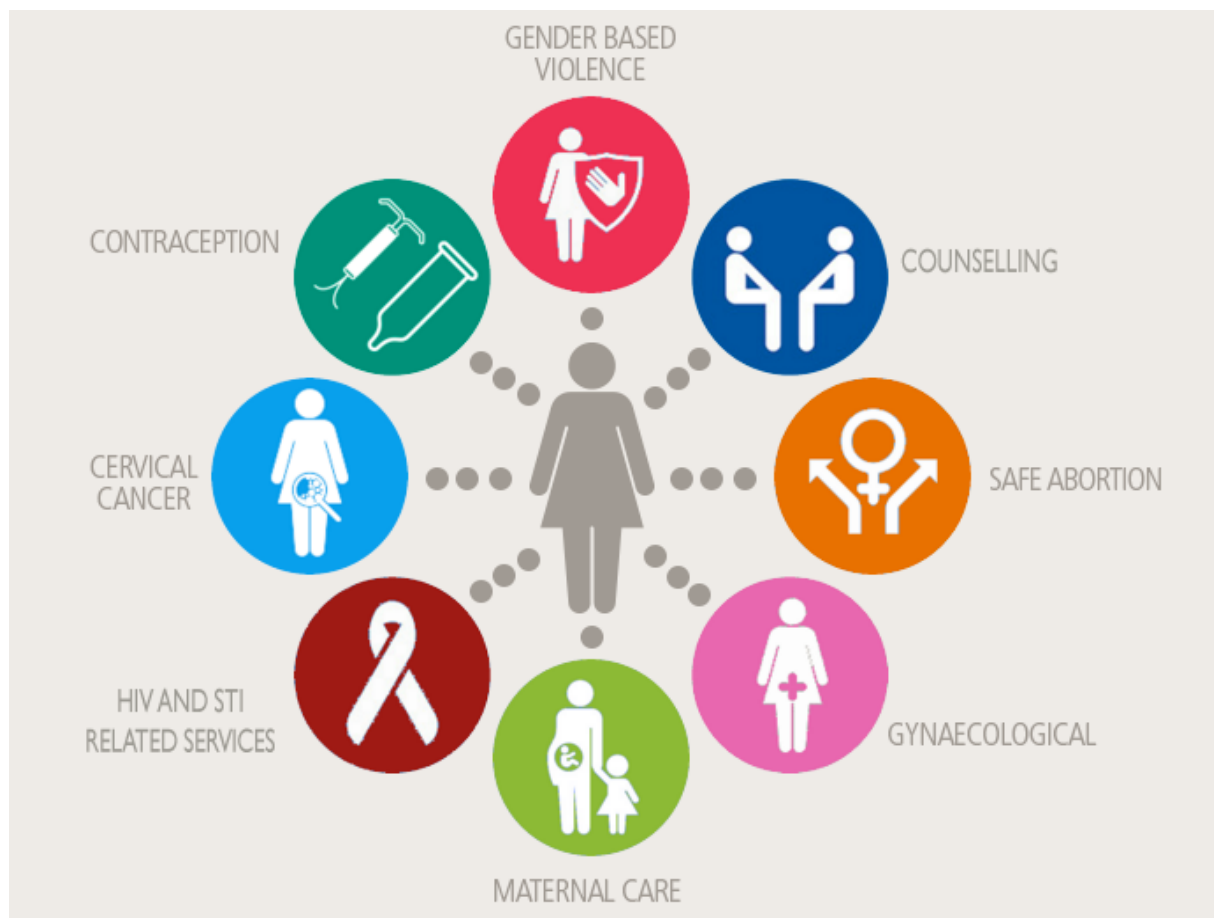
Chapter 2 will discuss in detail the relevance of aforementioned literatures. Here I provide a synopsis of integration in the UK and Scottish contexts, referring to and reviewing both policy documents and empirical research, in order to provide background to the context within which my research was conceived and took place.

1.2 A background to integration

‘The rationale for integration is to increase the effectiveness and efficiency of the health system and to meet people’s needs for accessible, acceptable, convenient, client-centred comprehensive care. This should include prevention of ill-health, provision of information and counselling, screening, diagnosis and curative care and/or referral for a full range of sexual and reproductive and other health-care needs’.

¹ I use the term ‘represented’ throughout, in order to express the co-constructed, as opposed to objective, nature of the text. As Rapport (2014: 270) notes, ‘texts do not simply come from nowhere and they do not give unto an unbiased reality’, thus, the thesis is a ‘situated text’, and the account told are representations.

(WHO 2006)



Integrated care graphic (International Planned Parenthood Federation, n.d.)

The WHO description of integrated health care above offers a concise summary of the intended outcomes of integrated care, namely, to provide improved health systems efficiency (and associated cost effectiveness) through provision of horizontal, holistic services that are believed to benefit service-users. The additional IPPF image further summarises the services ideally captured under the rubric of integrated care (although focused primarily on providing such care to women and girls in the Majority world). Yet, the ideals of integration as expressed through the WHO and IPPF can, in part, be identified in the UK context also, to which I now turn.

In the UK², the provision of sexual and reproductive healthcare has historically been available through the specialties of genitourinary medicine (GUM), HIV medicine, family planning

² For comprehensive review of international integration of sexual and reproductive healthcare see de Pinho et al (2005) and Church, K and Mayhew, S (2009).

(FP) and primary care (GP) (Sauer et al 2013; Gray et al 2009; Griffiths et al 2008; French et al 2006: 203; Melville et al 2004; Wilkinson et al 2000; Dawson et al 2000; Kane and Wellings 1999/2003; Stedman and Elstein 1995; Carlin et al 1995). GUM emerged in the wake of the First World War, in response to soldiers returning with venereal disease, and established itself as a curative, acute specialty working from within hospitals or dedicated clinics (Miners et al 2012; Bigrigg and Ilett 2010: 59; Wilkinson et al 2000: 187; Munday 1990: 66). With the emergence of HIV in the 1980s, GUM services in the UK expanded in order to address this new public health concern (BMJ Careers – Careers in Genitourinary and HIV Medicine). As Day (2007: 15) pointed out in her work with sex workers at a London-based GUM clinic, ‘GUM clinics acquired status with the advent of AIDS’. With its origins in Maternity and Child Welfare (Gillespie 2002: 213), FP emerged as a recognised specialty in 1974, having been granted official status and integrated into the NHS, after a long-fought battle for women’s contraceptive rights (Robinson 2009: 249; Lowe 2005: 361; Gillespie 2002: 214; Wilkinson et al 2000: 187). While GUM and HIV medicine practitioners focused on the pathology of their patients, FP emphasised prevention, providing attendees with contraceptive strategies delivered by women, for women, within the community (Kane and Wellings 2003: 355; Gillespie 2002: 214; Dawson et al 2000: 430; Kane and Wellings 1999: 135). From these divergent roots sprung two very different professional and care cultures (Kane and Wellings 1999). Since the early 1990s, however, (and as the above-cited WHO definition indicates) calls for the integration of GUM, HIV medicine and FP have gained traction in the UK (Hamlyn and Mezzone 2006; DoH 2001/2004).

Concerns over rising HIV and sexually transmitted infection (STI) rates, unintended pregnancies, and continued high demand for abortion led to questions being raised regarding the logic of ‘stand-alone’ services in the UK. It has been argued that the distinction between attendees of FP services on the one hand, and GUM and HIV medicine attendees on the other, may no longer be best suited to address the converging sexual and reproductive healthcare needs of the population (Moses and Huengsberg 2007: 208; French et al 2006: 204; Kane and Wellings 2003: 354; Dawson et al 2000: 430; Stedman and Elstein 1995: 342). Integration of services, it is argued, encourages comprehensive, horizontal sexual and reproductive healthcare provision by acknowledging the closely related needs of attendees (Robinson 2009: 249; French et al 2006: 204; Kane and Wellings 1999: 135/2003: 354).

An integrated approach to sexual and reproductive healthcare provision in the UK, which is understood as the integration of Sexual and Reproductive Health services (formerly FP) with Genitourinary and HIV medicine, was first mentioned in the UK's first ever national sexual health strategy, *Better prevention, Better services, Better Sexual Health: The National Strategy for Sexual Health and HIV* (DoH 2001), developed during the first two stages of *The National Survey of Sexual Attitudes and Lifestyles (NATSAL I, 1990 and NATSAL II, 2001)*³. The report emphasised that, while HIV rates in the UK were lower than those of many other Western European countries, infection was on the rise (DoH 2001: 7). It also noted that, due to increases in risky sexual practices between the 1980s and the late 1990s, particularly among the under 25s, (Johnson et al 2001) sexually transmitted infections (STIs) rose, while unintended pregnancies represented a serious on-going concern (DoH 2001: 5). The 2001 strategy, therefore, called for broad partnerships and collaboration between specialist services, primary care and the community, signalling an early development of an integrated framework for sexual and reproductive healthcare provision in the UK (Robinson 2009: 249; Moses and Huengsberg 2007: 208; French et al 2006: 202; DH 2001: 14). Three years on, the 2004 White Paper *Choosing Health: Making healthy choices easier*, maintained a focus on collaborative approaches to sexual and reproductive health while introducing OSSs as a further conduit for the delivery of integration (French et al 2006: 202; DoH 2004: 146). As Kane and Wellings (1999:132) put it, 'the coordination of FP and GUM services has the potential to boost the effectiveness of both, broadening opportunities for screening and preventive health checks and affording possibilities for raising a variety of sexual health problems'.

1.2.1 Scottish Policy

In Scotland, despite some fear that strong conservative values and a religious lobby would stifle the production of a sexual health strategy (Bigrigg and Glasier 2010: 60), the Executive's 2005 *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* (2005: 11) called for the establishment of enhanced links between primary care and

³*NATSAL I* was the first large-scale study of sexual lifestyles and attitudes using random sampling of the population. *NATSAL I* was funded by the Wellcome Trust and *NATSAL II* by the Medical Research Council. Results from the *NATSAL-3*, funded by the Wellcome Trust and the Medical Research Council, were released in autumn 2013.

specialist services in an attempt to address poor sexual and reproductive health among the Scottish populace. The policy acknowledged the negative impact of structural issues, such as social disadvantage, on sexual and reproductive health outcomes, whilst simultaneously calling for individual responsibility in reversing such adverse trends (Scottish Government 2005: iii).

In 2011, the Scottish Government published *The Sexual Health and Blood Borne Virus Framework: 2011-2015* (SHBBV), building on previous policy documents, including *Respect and Responsibility*. The 2011 framework reiterated the need for cross-sector cooperation and coordination in the fight against blood borne viruses and sexual ill-health. The framework's outcomes were listed as: fewer newly acquired blood borne virus and sexually transmitted infections and fewer unintended pregnancies; a reduction in health inequalities in sexual health and blood borne viruses; people affected by blood borne viruses living longer, healthier lives; sexual relationships being free from harm and coercion; and a society where the attitudes of the public, the media and professionals are non-stigmatizing and supportive (Scottish Government 2011: 5). As such, the 2011-2015 framework reinforced Scotland's 'ambitious vision for sexual health and blood borne viruses' which is based on principles of 'effective shared ownership and joint working with a strong focus on challenging inequalities' (own emphasis Scottish Government 2011: 1). With the latest findings from NATSAL-3 (2015: 34) finding that 'men and women in Scotland and Wales were less likely than those in England to have attended a sexual health clinic in the past five years' and that, out of the three nations, Scottish men and women were least likely to have been tested for HIV in the past five years, attracting individuals to these facilities and providing them with the opportunity for comprehensive services is an important public health priority.

The *Lothian Sexual Health and HIV Strategy 2011-2016* (Lothian Sexual Health and HIV Strategy Board 2011: 1) outlined a 'vision to improve sexual health...and to reduce ill-health caused by HIV'. The strategy outlined four goals: 'reducing harm from sexual ill-health and HIV; people with HIV live long and healthy lives; there are fewer unintended pregnancies; and people are able to make confident and competent decisions about sex' (LSHHSB 2011: 1). Building on the aims of the *Lothian Sexual Health Strategy 2005 – 2010, Respect and Responsibility* (2005) and the *SBBV (Sexual and Blood-Borne Viruses) Framework 2011-2015*, the present Lothian strategy outlined the 'Five Tiers of Sexual Health Services'

presently in operation across the region, which include community-based facilities providing information for individuals as well as low-level interventions (Tiers 1 and 2) through to Tier 5 ‘consultant-led specialist services’ (LSHHSB 2011: 10) – one of which is the facility at the heart of this research. Together, these UK and Scottish strategies point to a growing government interest in the provision of integrated, horizontal services that have the ability to practice opportunistic testing, offer comprehensive care and refer internally.

1.3 Integration-in-practice: Empirical studies of stakeholder opinion and experience

In this climate of change, concerns have been raised about the effect of integration on service-users as well as staff from divergent specialties. In addition to the editorials and opinion pieces mentioned above, which have outlined arguments for or against integration, there exists a small collection of published research on attendee views and experiences of integration-in-practice, focused overwhelmingly on what can be seen as the most tangible of integration strategies – the OSS (Sauer et al 2013; Gray et al 2009; Hitchings et al 2009; Sands 2009; Griffiths et al 2008; French et al 2006; Kane and Wellings 1999; Carlin et al 1995). Here I review this research, highlighting key findings from studies conducted with participants yet to experience integrated services through to retrospective studies with participants who, having been to such sites, reflect on their experiences. Having outlined key findings, I point to the gaps and limitations that my own research aims to address. Chapter 2 will then be dedicated to the conceptual literature that I engaged with during the planning of my research.

1.3.1 Studies ascertaining perceived acceptability of integration

Studies that engaged with stakeholder’s anticipatory views of integration reported general support for the idea of one-site integrated care, although with some reservations. Griffiths et al (2008: 395) aimed to assess the acceptability of various OSSs models (Young person, Enhanced GP and mainstream) among different community groups. Over an 8 month period in 2005, Griffiths et al conducted 19 in-depth interviews and 14 focus groups with young heterosexual men, MSM (men who have sex with men) and men and women from BME communities in order to ascertain their views with regards the acceptability of OSSs. None of these participants had ever been to such services before. The key finding of the study was that

‘regardless of model, respondents expressed preference for one provider/one session to provide GUM and contraceptive care’ (Griffiths et al 2008: 395), with one notable exception: the participants categorised as MSM. Among those who supported the idea of OSSs, there were differences of opinion regarding what type of OSS would be preferable and where such an OSS should be located. Concerns over the location and type of OSS service were commonly associated with anxieties over discreteness of service and fears of social stigma – both from the wider public and from others accessing or working within OSS facilities. Some saw the benefit of OSSs in that they would provide camouflage for those seeking oft-stigmatized GUM services (Griffiths et al 2008: 397). However, this point was raised with regards to women, while men noted that such cover was not available to them (Griffiths et al 2008: 397). For example, African men felt that the mainstream OSS would not be able to provide the discreteness required for accessing sexual health needs inconspicuously while gay men felt that they would be labelled as HIV positive if they were seen entering such a facility, with the former preferring the enhanced GP model, while the latter wished only to use GUM services (Griffiths et al 2008: 396-397). Thus, while some participants noted a general distrust of the confidentiality of GP-based OSSs, male participants argued that the GP-based model might be better for them, as this would provide them with ambiguity of attendance (Griffiths et al 2008: 397). Young men from rural settings felt apprehensions over being seen to attend a designated young-persons OSS facility, thus impacting the perceived desirability of such a clinic (Griffiths et al 2008: 396). Despite these differences in preference for the type and location of OSSs, participants agreed that accessibility should be supported through the provision of a flexible ‘drop-in’ service (Griffiths et al 2008: 398).

In their interviews and focus groups with MSM it was found that integration of services and the provision of care through OSSs was considered ‘highly unacceptable’ by almost all of these participants, with only a few suggesting that they believed integration might help in normalising sexual health (Griffiths et al 2008: 397). Anxieties were expressed by MSM participants over the anticipated loss of the supportive, intimate and specialist environment of GUM clinics, pointing to entrenched concerns that staff from FP settings would not ensure service-user confidentiality and remain non-judgemental when working with gay men:

‘What you want is that there isn’t going to be this judgemental person. When they say to you, how many sexual partners have you had and you say 332 that they aren’t going

to slump and look at you in absolute horror. So you need a service [like GUM] that is aware of what gay men's issues really are and can just take that in their stride'

(Participant, focus group, in Griffiths et al 2008: 397).

Finally, there was also worry that integrated OSSs might result in the dilution of the acceptance of 'gay issues' found within GUM clinics, with one potential outcome being the experience of homophobia in OSS waiting rooms (Griffiths et al 2008: 396). In sum, the Griffiths et al study provided insights into prospective attendees' views and concerns that pointed to issues around stigma, clinic culture, accessibility and staff attitudes.

Other studies that engaged with stakeholders in a prospective manner were focused on HCP views, rather than those of potential attendees. In-depth interviews were conducted with 25 HCPs from separate specialties of FP/WW and GUM in order to gain insights into views of integration and to consider 'the extent to which they may impede or enhance service integration' (Kane and Wellings 1999: 131). Echoing Griffiths et al (2008), the research with medical professionals found that views of integration were positive, for the most part, with the majority of those interviewed seeing a benefit to the integration of services in terms of ease and continuity of care (Kane and Wellings 1999: 134). Yet, this positive feedback was not without reservation. For example, there was some concern that attendees under the care of distinct services might find integration difficult – hinting at an appreciation of the change in clinic culture that might come with integrated services (Kane and Wellings 1999: 136). In addition and, again, echoing findings from Griffiths et al, medical professionals spoke of a concern over the stigma associated with GUM and how this might impact attendance to integrated OSSs (1999: 136-137). When it came to staff experience, participants in Kane and Wellings' research voiced concerns over the implementation of integration, questioning how diverse professional cultures could merge (Kane and Wellings 1999: 136). This finding was also echoed in research with 11 key informants involved in developing the *National Strategy for Sexual Health and HIV* (French et al 2006). In this research, in-depth interviews found that concerns as to the operationalization of integration-in-practice were linked to logistics and associated costs (French et al 2006: 202-205). With an appreciation of the reality that, under the integrated model, they would have to be trained in both areas of care, some participants voiced concerns over an anticipated loss of expertise in their own specialty, while others saw this as an opportunity to develop skills (Kane and Wellings 1999: 140-141).

In short, the findings from Kane and Wellings' research with HCPs prior to integration of services in the form of OSSs raised similar responses to those voiced by lay participants in the Griffiths et al research. While the general message was that OSSs were viewed positively, there were nevertheless concerns when it came to issues around the stigma associated with GUM, clinic culture, and staff attitudes. In addition, from a staff perspective (French et al 2006), concerns over the pragmatics of integration, the costs of integration and the expectation of broadening skills were raised.

1.3.2 In-situ studies

Anticipatory views of integrated services might be very different to the assessment of such services by attendees at integrated clinics. Studies conducted at integrated OSSs with attendees will be covered here, highlighting key findings and drawing out the similarities and differences when compared to more prospective research.

Providing women in the waiting room of a fully integrated facility with a 'stigma assessment questionnaire', Sauer et al (2013: 57) sought to 'assess whether women requesting contraception only' found their experience more stigmatizing than attendance at a FP-only clinic. The research found that stigma perception was 'significantly higher' among women seeking contraception only at the integrated site, when compared to women attending the FP clinic (Sauer et al 2013: 57). Specifically, the 'strongest disparity in concerns between clinics was disclosure concern' (Sauer et al 2013: 60). This meant that women attending the FP-only clinic for their contraceptive needs were '70% less likely than those who attended the ISHC to report fearing that they would run into someone they knew at the clinic' (Sauer et al 2013: 60). This research finding provides a clear example of how concerns about the stigma that might come with integration of FP with GUM services, voiced by participants of prospective studies, resonated with many of the women attending an integrated facility.

While concerns over stigma associated with the integration of GUM services with FP might be considered a key issue, the issue was not raised by attendees to an integrated facility in greater London (Hitchings et al 2009). In order to assess 'patient needs', a survey of patient views of integrated care was conducted using a 'point allocation system' in order to find out which elements of the service were more or less valued (Hitchings et al 2009: 719). During February of 2009, attendees to the 'walk-in' were invited to complete a two page anonymous

questionnaire as they waited (Hitchings et al 2009: 719). Each participant was provided with stickers to 'spend' on their most valued aspects of care, listed in the questionnaire, under sub-headings pertaining to interpersonal care, organisational issues and technical care (Hitchings et al 2009: 719). Of the 252 questionnaires returned, it was found that confidentiality of care, speed of service and rapid test results were most highly valued (Hitchings et al 2009: 721). Further, there was little difference in preferences between those attending for contraception or STI testing, with confidentiality most valued in both 'groups' (Hitchings et al 2009: 720). In addition, all attendees who completed the questionnaire indicated that, following confidentiality, speed of service and rapid test results, a friendly and non-judgemental atmosphere was considered valuable (Hitchings et al 2009: 719). Thus, stigma did not come up in this study, although perhaps this was because the questionnaire did not provide an opportunity for this issue to be raised by participants.

1.3.3 Retrospective studies

Two retrospective studies have been conducted which focused on attendee views of integrated services. These include a population based survey, comparing the use or preference for OSSs compared to control sites (Gray et al 2009), and a questionnaire to students of a FE college where an integrated service had been established (Sands 2009).

Gray et al (2009: 223) conducted a population-based survey asking about the use and preference for three different models of OSS services (Young person, specialist mainstream or enhanced GP) in relation to six sexual health needs. The study found that 'general practice was the preferred service provider cited for all sexual health needs, except condoms and pregnancy tests' (Gray et al 2009: 223). This result, then, differed from the findings of Griffiths et al (2008) who suggested that the GP model of integrated care would be least appealing to prospective attendees. Gray et al (2009: 233) suggest that GP practices should be examined further with regards their possible role in providing integrated services, this due to their favourable findings with regards accessing such services through primary care sites. Yet, as Gray et al (2009: 232) acknowledge, their study was limited by low participation rates (21.6%), impacting on the 'power' of the study. Finally, in her evaluation of students' views of a new integrated service at a community FE college, Sands found that students responded positively to the idea of a holistic service, housed in one location (2009: np). The main areas

for improvement identified by students were to reduce waiting times for services and to open the clinic five days a week (2009: np).

1.3.4 Summary of literature

Findings from this small pool of research have highlighted the heterogeneity of opinion among stakeholders regarding the OSS. These opinions were almost certainly influenced by the timing of their participation in the research, by which I mean whether their views were captured prospectively, in-situ, or retrospectively. Yet there were also some key concerns which appeared across most studies, notably the issue of increased stigma associated with GUM services and possible changes in clinic culture. While these findings relate to integrated contexts they are not, however, concerns that are unique to this new type of facility. Indeed, it is clear from reviewing a number of qualitative studies on the experiences of ‘stand-alone’ services that concerns around stigma (Dixon-Woods et al 2001; Duncan et al 2001; Pryce 2001; Scoular 2001; Darroch et al 2003; Lichtenstein 2004; Mills et al 2006; Leonard et al 2007; Mulholland and van Wersch 2007; Goldenberg 2008; Balfe and Brugha 2009, 2010; Sauer et al 2013), secrecy practices and confidentiality (Duncan et al 2001; Darroch et al 2003; Lowe 2005; Mills et al 2006; Mulholland and van Wersch 2007; Balfe and Brugha 2009, 2010; Fallon 2013), and the attitudes of staff and other attendees (Parker 2001; Lichtenstein 2004; Leonard et al 2007; Goldenberg 2008; Boydell 2010; Fallon 2013) all feature in participants’ accounts. With this comparison, then, the question is what makes experiences of integration different - if at all - from experiences of ‘stand-alone’ services. Of the two studies which directly compare preferences for ‘stand-alone’ versus integrated services (Gray et al 2009; Sauer et al 2013) it seems that the main concern is a perception of *increased* stigma, brought about by the association of GUM and HIV medicine with SRH services. By and large, however, it seems that the literature on integration points to heterogeneous opinions of the policy change that has led to the conclusion by members of the ‘One-stop shop evaluation team’⁴⁴ that ‘there can be no blue print one-stop shop model’ that will suit the preferences of all attendees’ (Griffiths et al 2008: 395).

There are limitations to these studies. Most are constrained in their ability to provide rich insider perspectives of an integrated service which is up and running, due to the methods

⁴⁴ A collective of researchers supported by the Department of Health to evaluate the impact of integration on stakeholders.

applied which, while both qualitative and quantitative, have failed to engage with experiences throughout the clinic journey, instead focusing on a single moment, be it anticipatory or retrospective. In addition, and perhaps due to their focus on evaluating service change, these studies have often made the integrated remit of the facility known to attendees who have participated in studies. While this has allowed key concerns regarding integration to emerge, I argue that the decision to highlight this service shift affected the perspective of participants and influenced the research results. Using the in-depth, ethnographic methods I deployed in my own research, in which I chose not to disclose the integrated status of the service, I found that attendees' accounts rarely suggested an understanding of the facility as integrated. This finding calls into question key parts of existing research on integration, which emphasised the perceived stigma attendees would feel, or had felt, when the integrated status of the service was highlighted.

It is within this context that I position my research as contributing further knowledge to our understandings of the experience of attendees to integrated OSSs, through the application of in-depth, ethnographically-informed methods which have not been applied to evaluations of stakeholder experiences of integration. As my methodology (Chapter 3) will describe in further detail, these methods were designed to allow participants to voice perspectives on their experience without being prompted to speak specifically to integration. This provided room for new insights to emerge and for these insights to be placed into a fuller understanding of the attendee's experience, in which integration often played a minor role, or no role at all, in comparison to weightier concerns. The findings chapters, and the discussion chapter which follows, will explore these results in detail.

Having provided the context to my research, I now introduce the clinic that was my field-site from January – December 2014. Following on from this overview, the introductory chapters draws to a close with an overview of the remainder of the thesis.

1.4 An introduction to the clinic

Following public procurement⁵ and subsequent closure of the existing facility in 2009, the clinic as it stands today was opened in June 2011. Led by eight consultants (three from

⁵ NHS Lothian providing £6.44 million and the Edinburgh Family Planning Trust, who owned the former FP property, donated a further approximate £1.7 million (EHP 2007: 18).

gynaecology and five from genitourinary medicine backgrounds) and staffed by approximately 120 personnel across both part-time and full-time positions, the clinic offers a broad spectrum of SRH, GUM and HIV medicine services to the city's population. These include 'walk-in' and booked appointments offering integrated care across a number of clinics, such as gynaecology, menopause, complex contraception, HIV, gay men's clinic, colposcopy, 'no-talk' testing (NTT) and general clinic, the last of which being where those to the 'walk-in' are seen if they do not fit into NTT. They also include 'sexual health services for young people, previously provided by Caledonian Youth; assessment and counselling for women requesting termination of pregnancy and early medical abortion services in the Choices clinic; the ROAM team⁶, providing services for men-who-have-sex-with-men; the Healthy Respect team; the Gender clinic; the C-card service; and vasectomy services' (Annual report 2014/15). The annual budget for the facility is £4.3 million, of which approximately £600,000 is spent on pharmaceuticals (excluding HIV medication, which is ring-fenced), while the majority of the funds are spent on staffing. At the time of my research (2013/2014) 39,546 individuals attended the facility. Ninety-three percent of attendees are reported as 'White' and, according to postcode information, the majority are from the least deprived areas of Lothian (Annual Report draft 2012 – 2013: 8-9), this indeed reflected in the demographic of participants in my research (see Chapter 4). In addition to the services provided to attendees, the facility is a teaching hospital which opens its doors to medical students from local universities and GPs for specialist training, indicative of their integrated, horizontal remit.

1.5 Outline of the thesis

Chapter 2 provides a review of the conceptual literatures I explored as I prepared for fieldwork. These included: theory and application of 'therapeutic landscapes'; understandings of the concepts of 'space', 'place' and 'affect' and; debates around different and changing models of the doctor-patient interaction. Mirroring the manner in which my own learning progressed throughout the research process, further literature is then referred to alongside findings and developed in Chapter 9.

⁶ Outreach testing service for gay, bisexual and MSM in Edinburgh and the Lothians.

Chapter 3 offers a description and justification of the research methods chosen for this study. Herein, I discuss my social constructivist approach to the research, the ethical considerations that I kept with me over the course of the PhD, and my rationale for who, how and why certain individuals were invited to take part in the research, together with other considerations.

Chapter 4 provides a bridge between the introductory chapters of the thesis and the four findings chapters. This interlude describes the care pathways that my participants were placed on, before introducing each of the individual attendees through short vignettes. The four findings chapters come next. These are presented sequentially, beginning with the approach and arrival to the facility, and will read as a representation of attendees' journey through time and space.

Chapter 5, 'Beginnings', represents and discusses the starting point on all attendees' journeys towards the clinic by considering their reasons for seeking the help of a health care professional at this specific facility. The chapter examines narratives that are suggestive of risk awareness, health consumerism and emotional relationship to place. In addition, the chapter examines how attendees – once in the periphery of the clinic – experience the affective landscape that they meet, namely, the combination of social and physical landscapes (Gesler 1992) of influence. The chapter demonstrates how, despite being a relatively brief moment in the trip to the clinic, time spent inside the periphery is nevertheless affective.

Chapter 6, 'Admission', focuses on attendees' onward passage through what I refer to as the 'sorting spaces' of the facility, namely, the main waiting room and triage, the atrium and smaller 'hub' waiting areas. Here, participants' accounts are considered in relation to the distinct affective characteristics of each of the spaces of temporary stasis, alongside considerations of the influence on participants' experiences of these spaces' temporal location within the journey of admission. The chapter highlights the emotional and intersubjective experience of waiting, and considers the role of architecture in rendering attendees docile.

Chapter 7, 'Consultations', takes us inside the consultation room. Understood as a site and interaction wherein 'new vital politics' is practiced (Rose 2001: 1), I examine the dual practice of care and surveillance that is undertaken by HCPs and consider the cooperative manner exhibited by attendees in their interactions with clinicians. I argue that discourses of personal responsibility and stigma linked to reproductive control and sexually transmitted

infection influenced attendees' behaviour in the consultation, making them grateful for, their care. Viewing their situation as acute, whether seeking treatment for an STI or time-sensitive fertility control, attendees wanted to 'get in and get out' with as little hassle as possible. I argue that this behaviour from attendees could be interpreted as them having been rendered "docile bodies" (Foucault 1977), but should also be recognised as a posture adopted for self-actualization - to do the right thing for self and society.

Chapter 8, 'Reflections', marks the end of the clinic journey and focuses on attendees' accounts with regards to two key questions. The first focuses on the meaning attendees attached to their visit to the facility, thus linking back to Chapter 5 somewhat while also making reference to the changes they felt they had undergone as a result of their time at the facility. The second question addressed in the chapter is the extent to which attendees understood the facility to be integrated or, otherwise stated, the extent to which their experiences of the clinic were informed by the facility's integrated status. The chapter will argue that the integrated status of the facility was more often than not unknown by attendees upon arrival and rarely influenced experiences. Finally, I consider why attendees - who I believed would be difficult to recruit - took part in the research.

Chapter 9, 'Discussion' reflects upon the key findings of the research and considers them in relation to existing knowledge. The chapter also addresses what I consider to be the strengths and limitations of the study and its findings, before delineating recommendations for practice.

2. Literature Review

2.1 Introduction

In this chapter I introduce and discuss the conceptual literature that I explored during the first year of my PhD when formulating my research plans. This literature, therefore, is located firmly in the early, deductive stages of the research, reflecting my own intellectual starting point and representing that which I felt to be relevant to my research topic. Naturally, as I conducted research and engaged in the practices of fieldwork, analysis and writing, a more inductive process was set in motion, with new literatures emerging as pertinent and informative.

The previous chapter outlined the main arguments for integration and the policy that contributed to this shift, in addition to reviewing the handful of existing empirical studies of integration in practice. Learning that integration brought with it a number of concerns as to the new characteristics of GUM, HIV medicine and SRH provision, I searched for literatures that might help make better sense of how an integrated OSS might be experienced in practice and from the perspectives of attendees. In this search, I found, both, the literatures on ‘therapeutic landscapes’ (Gesler 1992), and affective geography useful, so I address these here, describing these literatures in detail and showing how they informed my research questions. Finally, I considered what might be thought of as the ‘fundamentals’ of social theory on what place and space is. This chapter, therefore, focuses on conceptual literatures that I recognised for their potential salience for situating and understanding attendee experiences of an integrated facility.

2.2 ‘Therapeutic landscapes’ and affective geographies

Seeing that many of the concerns (and indeed perceived or experienced benefits) of integration related to the clinic environment, staff attitudes and expertise, and the presence of ‘others’ in these new facilities, I found the ‘geographic metaphor’ of ‘therapeutic landscape’ (Gesler 1992) a useful conceptual tool for thinking through how I might approach researching attendee experiences at my field-site. Originally applied as a means through which to examine the way in which naturally occurring landscapes and spiritual retreats were ‘associated with treatment or healing’ (Gesler 1992: 735 – 736), the concept has been applied to a wide variety

of subjects, including: the home (Williams 2002; 1999); summer camps (Dunkley 2009; Kearns and Collins 2000; Thurber and Malinowski 1999); gardens (Milligan, Galrell and Bingley 2004); the public library (Brewster 2014); self-help groups (Laws 2009); local parks (Plane and Klodawsky 2013); national parks (Palka 1999); and ‘everyday landscapes’ (Wakefield and McMullan 2005). An edited collection by Williams (2007) gathered a large number of studies using ‘therapeutic landscapes’ in a variety of contexts, from the ‘traditional therapeutic landscapes’ through to those for ‘special populations’, the application of the concept in health facilities and considerations of the un-therapeutic nature of place. Further, and as it has developed over time, the concept of ‘therapeutic landscapes’ has been applied to investigate the ‘constructed spaces of health... with attention to the ways in which... spaces may be un-therapeutic, as much as the ways in which they serve to perform particular therapeutic functions’ (Smyth 2005: 490). Examples include: psychiatric facilities (Wood et al 2015, 2013; Curtis et al 2007); hospital design (Crooks and Evans 2007; Gesler et al 2004); complementary therapy and imagined spaces (Andrews 2004); paediatric hospitals (Kearns and Barnett 1999; Adams et al 2010); the family planning clinic (Gillespie 2002); and; dementia care homes (McClean 2007). Within such facilities, as within the natural ‘therapeutic landscape’, physical (material), social (power dynamics and interactions) and symbolic (artefacts, objects and language) elements collide to create the environment. Moving beyond examination of the affective relationship between the individual and their physical surroundings, ‘therapeutic landscapes’ called for consideration of the affect created by ‘three interconnected environments’: the interpersonal, or social, the symbolic *and* the physical (Gesler 1992: 743; Wood et al 2013: 2).

Having introduced the concepts of the ‘therapeutic landscape’, in terms of its origins and component parts, I now focus on the application of the concept in the context of healthcare facilities, starting with physical landscapes and moving on to the social and symbolic. As will become clear, while it is conceptually convenient to conceive of these affective plains as separate, they nevertheless interact and influence one another.

2.2.1 Physical landscapes of healthcare facilities

In the era of consumer healthcare, architectural remits of healthcare facilities are no longer influenced only by utilitarian needs, but also by the desire to create, through bricks and mortar, a ‘therapeutic space’ (Smyth 2005). Seeking to foster a ‘sense of well-being’ among

attendees and staff (Gesler et al 2004: 123), spaciousness, ambient lighting, and colour in design are becoming ever more common (Gesler et al 2004: 119). In other words, ‘the therapeutic and the aesthetic have come together in recent years in significant...ways’ (Collins 2007: 352). Physical landscapes of healthcare facilities resonate with de Certeau’s ‘place’, and Lefebvre’s ‘representation of space’. They are material representations of decisions made by key stakeholders who conceive of them – order imposed and intended. However, in addition to this ‘aestheticization’ (Collins 2007: 351) physical landscapes are designed in line with organisational demands, such as ordering of people and efficiency. Consequently, we see how the physical and social landscapes converge. Having described the physical landscape of affect, I now reflect on social landscapes of healthcare facilities.

2.2.2 Creating social landscapes

The physical landscape functions to separate medical ‘experts’, medically trained staff, support staff and attendees (Gesler et al 2004: 118). In her observational study of the waiting room at a ‘family planning’ service, Gillespie notes that ‘outer’ areas comprised of entrances, toilets, reception and waiting area (lay) are contrasted by ‘inner’, professional, medical, private spaces (2002: 216). In addition, the ‘labour of dividing patients’ observed by White et al (2012: 73) at an A&E is facilitated through the creation of physical landscapes within healthcare facilities. Dividing of attendees has dual purpose, allowing for organisational demands such as ‘tracking the flow of patients’ progress through the diagnosis and treatment processes’ (Peters et al 2001: 141) while simultaneously creating and stifling social interactions between and across pre-determined ‘groups’ (Smyth 2005: 491).

‘Moments of access’ into various physical landscapes result from social interaction (the social landscape), whereby attendees must successfully present as ‘legitimate’ to staff (White et al 2012: 70). Such moments are hinged upon attendees’ ability to conform to the organisation’s standards of who constitutes an authentic attendee (White et al 2012: 70), or indeed their willingness to submit to organisational norms of medical surveillance, as Gillespie (2002: 213) notes in her observation of the, ‘panopticonic’ nature of the FP reception. Remaining with Foucault, these points are suggestive of his ‘fifth principle’ of the ‘heterotopia’ whereby heterotopic spaces:

‘Always presuppose a system of opening and closing that both isolates them and makes them penetrable...either the entry is compulsory...or else the individual has to submit to rites and purifications. To get in one must have certain permission and make certain gestures’.

(Foucault and Miskowiec 1986: 26).

The key point, then, is that social landscapes are often pre-determined through the use of physical design. As will soon be discussed, for theorists such as Foucault, the power of such engineering is substantial, however others, including Lefebvre and de Certeau, suggest that human interaction with an environment results in some degree of re-construction. Therefore, although the physical landscape has the potential to impact the parameters and possibilities of the social, it could be argued that it is always occupied and acted upon by a ‘set of social actors’ (McLean 2007: 71). Once new healthcare facilities are completed ‘construction and reconstruction’ occurs (Collins 2007: 364) engineered by those within the environment. Gieryn (2002: 44) argues that the structuring force of buildings is limited, as over time the designs of architects are subject to ‘the hands of human agents for more or less creative redefinition, re-evaluation, and even re (or de-) construction’. This process is described by Gieryn (2002: 53) as the ‘moments’ between agency (the design of the building), ‘structure’ (the affect of the building on actors) and ‘agency’ (the reconstitution of the building by actors).

2.2.3 Symbolic landscapes

Symbolic landscapes constitute the artefacts, language, and objects within a therapeutic space (Smyth 2005: 490). Language, both written and spoken, constitutes a central element of the symbolic landscape. Language is simultaneously influenced by (Gesler 1994) and constitutive of (Tuan 1990: 236; Auge 1995: 77) the physical landscape. Indeed, the performative aspect of language – the actions and gestures which accompany the spoken word – ‘not only requires but commands its own kind of space’ (Tuan 1990: 236). In the healthcare context, language is highly symbolic, not least because the ways in which doctors and lay people talk about health changes over time (Foucault 1991; Gesler 1994). For example, the naming of ‘therapeutic spaces’ (Gesler et al 2004: 120) has social-symbolic relevance.

Linking back to the aestheticization of healthcare spaces, the addition of commissioned artwork has been critically examined as part of, not only the physical landscape but also the

symbolic (Evans et al 2009). The presence of art in healthcare settings, usually depicting ‘therapeutic places’, (Evans et al 2009), is often commissioned, and decided upon by upper management (DoH 2007). This ‘top-down’ art, while sometimes appreciated by attendees, is also symbolic, perhaps, of the *habitus*, to use Bourdieu’s terminology, of decision-makers. There may be, in fact, discordance between ‘the perceptions of what constitutes a *therapeutic environment* held by users on the one hand (for example staff and patients) and planners, policy makers and managers...on the other’ (Collins 2007: 357 – 358). Taking this further, Evans et al (2009: 718) note that ‘the seemingly innocuous presence of environmental art in hospital settings’ functions to create docile patients through their soothing affect. In this view, artwork functions as a tool for a power-laden process (Evans et al 2009: 718). While I am unsure of the conspiratorial tone of this observation, it is certainly interesting to consider the impact of environmental artwork on attendees and staff within healthcare settings.

2.2.4 Summarising ‘therapeutic landscapes’

It is evident from the concept’s utilisation as an analytical tool in a wide range of research that ‘therapeutic landscapes’ is understood as offering a comprehensive lens through which to examine the influence of place on experience, with place being understood as the confluence of physical, social and symbolic affective fields. This seems a highly appropriate lens through which to examine experiences of an integrated OSS, for at the heart of this policy shift is *intention* to change the social make-up of the clinic by bringing together once considered divergent groups in one physical landscape, the clinic. Yet, and certainly in the examples of ‘therapeutic landscapes’ as applied to transient healthcare facilities such as the OSS, there is a lack of consideration as to the possible influence of the affective landscapes on people’s experiences, as they pass through the facility. Thus, in applying the conceptual lens to the examination of attendee experiences of an integrated OSS, I felt that my research might address this gap.

So far I have focused on ‘therapeutic landscapes’ and the analytical potential for this concept in helping me interpret my findings. I now move on to consider affective geographies and atmosphere for, while ‘therapeutic landscapes’ helped in focusing attention towards the potential sources of different affects (the materiality of the site, the relationships established within, the power dynamics at play and the like), it was necessary to grapple with the question: how can we, first, access experience and then, represent it in the form of findings?

2.3 Affective geographies and atmosphere: can we harness experience of place?

Given the focus on exploring attendee experiences of a fully integrated sexual and reproductive healthcare facility, it is necessary to consider the question of how one might access said experiences. While this issue will be discussed further in Chapter 3 in relation to the methods applied to the research, it was literature on affective geography that I found informative in my first year, and it is to this that I now turn.

Affective geographies speak to the ‘therapeutic landscapes’ concept sympathetically being concerned with the ‘energetic outcome of encounters between bodies in particular places’ (Conradson and Latham 2007: 232) while also stressing that ‘affect’ is not ‘bound to particular individual bodies’ (Bissell 2010: 271), instead drawing attention to ‘the importance of considering some of the nonhuman forces that mobilise and mediate [social] relations’ (Bissell 2010: 272). Put simply, affect, as expressed by scholars from the perspective of affective geography, points us towards the relations between ‘bodies, objects and technologies’ (Bissell 2010: 272). In this way, then, ‘affect’ is a useful lens through which to examine place, space and experience thereof, for it emphasises the inhabited (both human and non-human) character of environments. Not to be mistaken with emotion or feeling, affect is positioned as being pre-cognitive, or pre-conditioned. McCormack’s (2008: 414) definition aids us in our differentiation of words not uncommonly used interchangeably, saying ‘affect is a pre-personal field of intensity, feeling as that intensity registered in a sensing body, and emotions as that felt intensity expressed in a socio-culturally recognizable form’. Affect, then, is positioned as the pure, essential force which is then filtered through embodied, social registers in order to be sensed and expressed. Pile (2010: 8) makes this point also, stating the order: affect, translation and cognition, emotion, and with this process, there is a loss of integrity of affect. In addition to ‘emotion’, affect is at times conflated with ‘atmosphere’, as Anderson (2009: 78) notes, ‘in everyday speech and aesthetic discourse, the word atmosphere is used interchangeably with mood, feeling, ambience, tone and other ways of naming collective affects’. What ‘atmosphere’ and ‘affect’ share in common is a certain inaccessibility, as existing outside of, or beyond language (Bohme 1993: 113). Yet, somewhat paradoxically, the word is used to relate to specific situations in common parlance, for example, ‘applied to persons, spaces and to nature’ (Bohme 1993:113). We can recognise

that ‘on entering a room one can feel oneself enveloped by a friendly atmosphere or caught up in a tense atmosphere. We can say of a person that s/he radiates an atmosphere’ (Bohme 1993: 113). So, what is the difference between ‘affect’ and ‘atmosphere’? Bissells (2010: 273) suggests that the relationship between affect and atmosphere is that the latter is the spatialisation of the former, while others (Bille, Bjerregaard, Sorensen 2014: 1; Kraftl and Adey 2008: 216) collapse the distinction, instead choosing to speak of ‘affective atmospheres’. What is clear is that both affect and atmosphere, despite their certain indeterminacy, can be engineered through the built environment, or ‘staged’, as Bille, Bjerregaard, Sorensen (2014: 1) and Kraftl and Adey (2008: 216) both suggest in their studies of ‘staging atmospheres’ and ‘architecture, affect and inhabitation’, respectively. Architects intentionally engineer atmosphere and affect within spaces, through the intentioned use of objects, light and symbols. Yet, (and as will be discussed below in considerations on space and place), we cannot assume that intentioned affect is immutable. Rather, atmospheres are ‘perpetually forming and deforming, appearing and disappearing, as bodies enter into relation with one another. They are never finished, static or at rest’ (Anderson 2009: 79). Further, atmospheres can be understood as owned by ‘the subjects that “apprehend” them’ (‘they belong to the perceiving subject’) but they are also vague things that belong to and ‘emanate’ from the material, aesthetic object/s (Anderson 2009: 29). Of the ontology of atmosphere, Bohme (1993:114) says:

‘Atmospheres are indeterminate above all as regards their ontological status. We are not sure whether we should attribute them to the objects or environments from which they proceed or to the subjects who experience them. We are also unsure where they are. They seem to fill the space with a certain tone of feeling like a haze’.

The easiest way to think about this is that atmosphere has a ‘*propensity*: a pull or a charge that might emerge in a particular space which might (or might not) generate particular events and actions, feelings and emotions’ (Bissell 2010: 273).

How are we to access, and represent, affect and the influence of affective atmospheres on experience? McCormack (2008: 1828), in his study on the affect of dance and spaces thereof, raises this problem convincingly as he says, ‘you know that this is true, because you know how a room of moving bodies feels before you could ever put that knowledge into words’. Thus, affective geography opens itself up to criticism, such as that put forward by feminist

geographer Bondi (2005: 438) who asks, ‘‘how can our own texts ever honour that which lies beyond the scope of discourse?’’. Not wishing to give up ‘the importance of inexpressible affects’ (Pile 2010: 7), affective geographers and non-representational theorists note that, in order to move beyond the inaccessibility of affect and atmosphere in language, we must rely upon observational, non-verbal registers of communication, thus challenging the ‘privileging of cognition’ that expressions of emotion imply (Bondi 2005: 437).

2.4 Space, place: Theoretical contributions

This section of the literature review outlines key theoretical concepts that I identified in the early stages of my doctoral research and which I used to help inform my study design and research focus. Having identified ‘therapeutic landscapes’ as useful analytical tool for thinking about how and for what reasons attendees might experience the integrated OSS, and followed this up with literature that helped me to reflect on the possibilities and limitations in accessing people’s experiences of place, I found myself back at what might be considered the beginning, that is, asking myself what everyday terms such as ‘place’ and ‘space’ meant and how I might use these terminologies to interpret my findings. In this search, I engaged with the contributions of scholars including Michel de Certeau, Yi-Fu Tuan, Henri Lefebvre, Michel Foucault, and Marc Augé.

2.4.1 Defining ‘space’ and ‘place’: de Certeau, Lefebvre, Foucault and Tuan

For de Certeau (1984:117) space (*espace*) and place (*lieu*) are constructed in relation to one another. Place is conceptualised as ‘the order (of whatever kind) in accord with which elements are distributed in relationships of coexistence’, while space is understood as places *brought to life* - ‘the street geometrically defined by urban planning is transformed into a space by walkers’ (de Certeau 1984:117). Thus, while places are *intended* - designed with certain actions and parameters in mind - it is through human interaction with place that spaces are created (de Certeau 1984: 117). Massey (2013) appears to make a similar case, saying ‘space concerns our relations with each other and in fact social space, I would say, is a product of our relations with each other, our connections with each other’.

Tuan, however, chooses opposite terminology to express something very similar. In his definition, it is *place* which is created when individuals and their senses are exposed

completely to an otherwise abstract and blurry entity of space (1977: 18). Consequently, place is commonly associated with feelings of familiarity, or even security, whereas space is associated with the unknown, and freedom (Tuan 1977: 3). What is interesting about these concepts is that regardless of whether it is ‘space’ (de Certeau) or ‘place’ (Tuan) which is generated, lived and experienced, both speak of the transformative influence of human journeys, interactions and movements with and within the environment which, ultimately, conceive the setting.

Lefebvre, despite using the word ‘space’ exclusively, seems to make a similar observation on this distinction between place and space. In dissecting ‘space’ Lefebvre refers to ‘representations of space’ and ‘representational spaces’, the former referring to environments of intent, while the latter refers to spaces which are lived, and subject to change as a result of their ‘qualitative, fluid and dynamic’ quality (Lefebvre 1991: 33/42). However, for Lefebvre ‘representations of space’ are intimately connected with power - the ‘dominant order’ of a society - and are, thus, evidence of an imposed order (Lefebvre 1991: 33; Mitchell 1995: 115; Stewart 1995: 610). Lefebvre regards ‘representational spaces’, then, as ‘clandestine’ or ‘underground’ spaces of resistance which are imbued with symbolism (Lefebvre 1991: 33). Crucially for Lefebvre the relationship between ‘representations of space’ and ‘representational space’ is one of potential coexistence, concord, or interference (1991: 41).

Like Lefebvre, Foucault understands space as contested and bound in power dynamics. His interest in ‘spatial relations’ – the ways in which people, activities and buildings interact (Philo 1992: 151) – is evident in much of his work, not least in *Discipline and Punish* (1977) in which he described the way ‘discipline proceeds from the distribution of individuals in space’ (1977: 141). Furthermore, once individuals are subject to distribution in space, they are then also the subjects of the ‘gaze’ – a ‘disciplinary mechanism’ which is capable of recording all movements and events (1977: 197). For Foucault, the physical impacts on the individual or collective social body of disciplinary mechanisms were designed to preclude the possibility of subversion or resistance.

2.4.2 Anthropological place and non-place: Augé

Augé constructs a polarised distinction between the nature of anthropological place and ‘non-place’ (1995: 79). For Augé (1995: 81), places are symbolized, anthropological and

comprised of the ‘the journeys made in it, the discourses uttered in it, and the language characterizing it’. Places ‘want to be – people want them to be – places of identity, of relations and of history’ (1995: 52). Such places can be understood as ‘geometric’, formed of the ‘routes, axes or paths that lead from one place to another and have been traced by people’ (Augé 1995: 57). Places, then, are created by people, over history and they are deeply affective. Conversely to place, Augé (1995: 78) argues that ‘super modernity’ has created ‘a new object’ of study – the ‘non-place’. Characterised as ‘fleeting’ and the ‘temporary’, these ‘non-places’ have no history, and are instead ‘assigned to a circumscribed and specific position’ (1995: 78). Examples of such ‘non-spaces’ include travel infrastructure such as motorways, airports, train lines, cars, aircraft and trains as well as hotels, and retail ‘outlets’⁷ (Augé 1995: 79). Therefore, Augé contributes by highlighting the relevance to research of new spaces – the ‘non-places’ – of social life.

In the context of this study, the consultation room is *the* space wherein integration takes place, and the material space on which my participants directed most of their focus. As a result, I was interested in looking at existing literature on the doctor-patient relationship in the context of sexual and reproductive health care facilities.

2.4.3 Doctor-patient interactions: models and on-going debates

Since Parsons’ (1951) and his characterization of the ‘sick role’, the doctor-patient interaction has been the topic of significant research and commentary (Dew et al 2016:7; Williams 2005: 123). Reflecting on the face-to-face interaction as a site of power asymmetry, or the interaction as a site for the reproduction of wider social norms, the consultation has been understood through both micro and macro lenses (Nettleton 2013: 123). Here I introduce and outline four models of the doctor-patient interaction in terms of treatment decision-making, reviewing developments in approaches. I start with Parson’s ‘sick role’ and the paternalistic model.

Writing from a structural-functionalist perspective, Parsons saw illness as a state of social deviance that was to be redressed by the medical establishment (Dew et al 2016: 8; Williams 2005: 124; Parsons 1951). In order for this to work, both the patient and the doctor had

⁷ Interesting is the fact that the facility where my research was conducted used this terminology for their centre.

access to certain ‘rights’, but were also obliged to act in their distinct roles (Dew et al 2016:7; Williams 2005: 124; Emanuel and Emanuel 2002; Parsons 1951). As Nettleton (2013: 125) suggests, then, the relationship was one of unequal reciprocity, with each of the social actors reliant upon the other for their own status. In the Parsonian model of the doctor-patient interaction, then, the patient is provided the status thereof, and without blame for their illness, *on the condition* that they, in turn, will actively seek the help of an expert and do what is necessary to get better (Dew et al 2016: 8-9; Williams 2005: 124; Parsons 1951). Thus, the right to be exempted from social responsibility during a period of illness is contingent upon their cooperation and ‘deference to professional authority’ (Charles et al 1999: 652). These are the conditions of the ‘sick role’. For the practitioner, the right to their own more powerful status nevertheless is linked to a great responsibility to restore the sick individual back to their healthy status from one of social deviance, expediently so, using their technical expertise to do so (Dew et al 2016: 9; Williams 2005: 124; Parsons 1951). The practitioner must be objective, altruistic and serve in the patient’s best interest (Dew et al 2016: 9; Emanuel and Emanuel 1992: 2221; Parsons 1951). The paternalism that characterizes the Parsonian doctor-patient interaction is, thus, understood for its intrinsic power imbalance, whereby the practitioner holds the monopoly in terms of power, as they dictate and dominate the medical encounter in order to diagnose and treat, using their technical expertise to do so (Charles et al 1997: 683). The consultation is, thus, a site for ‘social control’ which can be regarded as providing both an “insulating” and “reintegrative” function’ (Williams 2005: 130).

The ‘sick role’ and the paternalistic model have been subject to criticism on a number of counts, with the paternalistic model of the doctor-patient interaction having ‘fallen out of favour with the provision of “patient autonomy, control and patient challenge to physician authority”’ (Charles 1997: 682). The ‘sick role’ and associated paternalistic model has been criticised for its ‘limited applicability’ to chronic illness (Dew et al 2016: 9; Williams 2005: 125), when patients may well develop ‘extensive experiential expertise’ that might require a less hierarchical interaction (Dew et al 2016: 13). Further, the ‘sick role’, specifically, does not apply to those who attend the doctor preventatively, as opposed to being in a state of ‘deviance’ (or ill-health) (Dew et al 2016: 9). In addition, the ‘sick role’ allows for little consideration of social determinants, such as class, gender, age and ethnicity on experience (Dew et al 2016: 10; Williams 2005: 125). Finally, there is some issue with the foundational assertion that ill-health is a form of ‘deviance’ (Dew et al 2016: 9).

With these criticisms levied against Parson's functionalist understanding of the 'sick role', the paternalistic model of the doctor-patient interaction has also been challenged by the emergence of neoliberal consumerist ideals (Dew et al 2016: 12; Nettleton 2013: 124; Lupton 1997: 373; Charles 1997: 682; Haug and Lavin 1981: 213), the decline in the social status of physicians (Dew et al 2016: 11; Lupton 1997: 379) alongside the increasing availability of health information online (Dew et al 2016: 12). At the heart of each of these challenges to paternalism is the issue of power within the doctor-patient interaction. With a strong trend towards patient responsibility, and 'the concept of the "health consumer" [encapsulating] a new understanding of the role that recipients of healthcare should have' (Dew et al 2016: 8), new approaches to the doctor-patient interaction have emerged, namely, 'professional-as-agent' (Charles et al 1997) or 'interpretative' (Wirtz et al 2006), 'shared' decision-making and, 'informed' decision-making.

While in the paternalistic model it is the HCP who holds sway over proceedings and dictates, in a one-way interaction, to a willingly submissive patient the course of action (Dew et al 2016: 14), the 'informed' model assumes the opposite: that both the HCP and the patient are experts in their own right, of different sorts of knowledge (embodied, for the patient and technical with regards the HCP) and, subsequently, an exchange of these knowledges is undertaken prior to responsibility for the final decision being handed to the patient (Dew et al 2016: 14; Charles et al 1999: 654; Charles et al 1997: 683; Emanuel and Emanuel 1992: 2221). In this model, crucially, it is the patient's sole responsibility to decide upon their treatment preferences, having provided the physician with all of the necessary information and, in turn, received 'facts' from the physician as to options available. While the 'informed' decision-making model may be regarded as the epitome of consumer choice, it can also be viewed as a means for the HCP to abrogate responsibility (Nettleton 2013: 129), asking too much of ill and, at times, vulnerable patients (Dew et al 2016: 14). Further, this idealised model is linked to notions of rational choice based upon reflexivity and consumerist practices which, being highly individualised, do little to consider the 'dynamic and intersubjective sociocultural process' that influence behaviours (Lupton 1997: 374). Thus, in the doctor-patient interaction it is perhaps more appropriate to seek a balance between paternalism on the one hand and absolute patient autonomy on the other (Nettleton 2013: 129). In this middle ground are located the other two approaches to the doctor-patient interaction, that is, 'shared' decision-making and 'professional-as-agent' or 'interpretative' approaches. 'Professional-as-

agent', or 'interpretative' models see the practitioner make the decisions, but based upon a prior discussion with the patient with regards what matters to them, their health and lifestyle (Dew et al 2016: 14; Charles et al 1997: 684). Thus, 'interpretative' or 'professional-as-agent' approaches to treatment decision-making results in the practitioner deciding upon a course of action. Shared decision-making, unlike paternalism, informed and professional-as-agent, is built upon the idea that both actors, rather than one, should come to a decision together (Dew et al 2016: 14) and has become a popular - if somewhat confusing - approach to treatment decision-making (Charles et al 1999: 651). Summarising the key principles of the shared decision-making approach, Charles et al (1999: 652) say 'at a minimum, both the physician and patient are involved in the treatment decision-making process'. This is followed by 'both the physician and patient shar[ing] information with each other', with both parties taking steps to 'participate' in treatment decision-making and implementation thereof (Charles et al 1999: 652). Fostered correctly, the shared decision-making approach is based upon mutual respect and collaboration in all aspects of the process of treatment (Emanuel and Emanuel 1992: 2224).

In sum, social science research has pointed to the suggestions that 'lay people want to, can and do play an important part in interactions with trained healthcare workers' (Nettleton 2013: 123), yet this must be read both in terms of the desire for more agency in the consultation *and* the desire to be submissive. As Williams (2005: 132), in his article revisiting the 'sick role' points out, 'lay people...may pursue both the ideal-type 'consumerist' and 'passive patient' subject positions *simultaneously or variously* depending on the context in question'. Thus, despite contemporary approaches seemingly championing the more 'empowered patient' models, it is perhaps more appropriate to suggest that decisions about which 'type' of interaction is best should not be universalised but, instead, based upon considerations, including patient preference (Wirtz et al 2006:118-119; Charles et al 1997: 686).

2.4.4 The doctor-patient interaction in the context of sexual and/or reproductive healthcare

When it comes to doctor-patient interactions in the context of sexual and/or reproductive healthcare, there are relatively few studies which discuss attendee attitudes, behaviours and preferences. This gap will surely be linked to the larger issue, namely, that sociological

studies of sexual health have often overlooked ‘micro-level interactions in sexual health services, especially from patients’ perspectives’ (Nack 2008: 14). Pryce (1998) referred to this gap as the ‘missing’ sociology of ‘VD’ almost two decades ago and yet, it appears this gap still remains. Writing again in 2000, Pryce (2000: 295) reiterates the point, saying:

‘Despite the historical significance of sexually transmitted diseases, the social and professional stigma attached to the genitourinary medicine (GUM) clinic has to some extent rendered it marginal to the dominant hospital/clinical disciplines. This is reflected in its relative invisibility as a focus of inquiry as a social system, an arena for the interpenetration of two powerful discursive formations, medicine and sexualities’.

This, of course, notwithstanding the extensive research on HIV and AIDS. Yet, there are some examples of studies which address the issue of the doctor-patient interaction in the context of sexual and/or reproductive healthcare and here I review some of the main points therein.

In her examination of the ‘medical and social dynamics of college women’s interactions with their gynecologists’ Griffiths (1997: 398) suggests that, despite women’s reduction to passive object in the consultation being viewed by the women’s health movement as a sign of physician dominance, women themselves were implicated in their relative powerlessness. All but one of Griffith’s twenty women interviewed seemed to easily accept the gynaecologist’s authority in their interactions (1997: 400). Griffith (1997: 401) notes that this acceptance of the practitioner’s authority was linked to the vulnerability that women in her research experienced, in particular as linked to the intimate examination. The requirement to be ‘naked’, in front of a ‘virtual stranger’ was exacerbated by ‘the physical position of lying on a table with one’s feet in the stirrups as well as the emotional position of being powerless in the interaction’ (Griffiths 1997: 401).

Recognising a similar behaviour in her ethnographic research of the pill, Boydell (2010: 88) notes that while contraceptive options, such as the pill and LARC are championed as having provided women with freedom and control over their fertility, the fact remains that in order to access such technologies, women must undergo ‘the pragmatic negotiation of clinical bureaucracy’ necessary in order to be prescribed (Boydell 2010: 88). As a result, women in Boydell’s study would often present themselves as passive, as a strategy to get what they wanted, with Boydell (2010: 91) writing of one participant, Louise’s demeanour, ‘though the

routine encounters were infantilising, Louise was fully aware that if she presented herself as ‘very passive’...like a child, she would get the pill. She found this humiliating but effective’. Thus, adopting a passive role was an active consideration, a strategy, in order to achieve ‘clear objectives in the clinical encounter’ (Boydell 2010: 99).

Pryce (2000: 104), writing of the social construction of male sexualities at a GUM clinic, understands the consultation and the doctor-patient interaction as a site for ‘the interpenetration of two discursive formations, medicine and sexuality’. Yet, he suggests that there is resistance to medical dominance within the consultation, as both practitioner and attendee perform in ways which serve their interests, for example, ‘the client may resist surveillance and control through selective, consumerist use of services and limiting the extent of their disclosure of sexual risk or activities’ (Pryce 2000: 104).

What we see, then, from these accounts of the doctor-patient interaction in the context of sexual and/or reproductive healthcare is a tendency for patients to be more inclined to present as cooperative recipients of care. This cooperation, however, should not be mistaken for passivity. Instead, we see the deployment of strategic cooperation in order to secure the outcome individuals desire – be this contraception or sexual health advice without the disclosure of more than individuals might wish. As will become clear (Chapters 7 and 9), participants in my research also exhibited this type of behaviour in the consultation, adopting what appeared to be an assertive, yet cooperative demeanour in order to secure the care they sought in a timely manner.

2.5 Reflections on the salience of these literatures and presentation of research focus

As indicated at beginning of this chapter, in addition to engaging with existing studies of integration-in-practice as part of my preparation for fieldwork, I felt it informative to engage with literatures which would allow me to better understand how to explore people’s experience of particular places, not least because my field-site was a purpose-built facility, bringing together traditionally separate attendees in an intentioned designed space. In this endeavour I was drawn to literatures from social geography, including ‘therapeutic landscapes’ and affective atmospheres. Following this, I focused on literature pertaining to the

doctor-patient interaction, not least in the context of sexual and reproductive healthcare. This interest was driven by an awareness that integration is implemented during the consultation, primarily, and so I anticipated that the consultation would be a central site for my research. It was during the time looking at literature on the doctor-patient interaction that I learned of the dearth of in-depth, qualitative research focused on the consultation interaction in the context of sexual and reproductive healthcare, thus, seeing a gap that my own research might address.

2.6 Conclusion

This literature review, in conjunction with the review of integration-specific literature in the previous chapter, has introduced and discussed the literature which influenced the way in which I conceived of my research, in terms of its place within existing knowledge. As indicated at the beginning of this review, conducting fieldwork and analysing findings brought with it engagement in other, new literatures which will be referred to throughout the thesis as a reflection of the more inductive stages of fieldwork, analysis and writing up.

3. Methodology

3.1 Introduction

This chapter provides the details necessary for a critical appraisal of how, and for what reasons, this PhD was undertaken, by providing a clear and persuasive rationale for my choice of study design. This study focused on evaluating the experiences of attendees to a purpose-built, fully integrated sexual and reproductive health care facility, using ethnographically-informed methods, for reasons to be detailed below.

I begin by reflecting on my ontological, epistemological stance and methodological influences. These convictions provide the lens through which I interpret the world and, thus, influence my research practice. Next, I turn to the preparatory work that I engaged in prior to starting fieldwork, including a period of acculturation that helped to inform my study design. I then discuss my rationale for the methods that I applied to the task of learning of participants' lived experiences of the facility, introducing each method, discussing its respective strengths and weaknesses, and describing how I adapted it to the field. The chapter then focuses on selection decisions and recruitment strategies, which were necessarily different for each group of participants. Ethical considerations are discussed throughout the chapter, representing what I felt was the on-going necessity to practice process ethics over the course of the PhD, from planning through to implementation and dissemination. The chapter then draws to a close with discussion of my experiences of fieldwork and approach to analysis before reflecting on my role in the co-production of knowledge represented in this study.

3.2 Ontology, epistemology: An ethnographic lens

In this first part of the chapter, I describe how I planned for fieldwork. I start with a reflection on my ontological and epistemological stance, which I consider to be founded in my personal experiences and biography, and further nurtured by my undergraduate and postgraduate studies in social anthropology.

As researchers we approach the world through our own particular 'basic belief system', and it is this 'paradigm', or lens, that we must be aware of, for it influences our practice of social science (Guba and Lincoln 1994: 105). I recognise in myself postmodern, interpretivist

leanings. That is, I am concerned with the multitude understandings of the world in which we each find meaning. This is not to say that I reject the existence of certain entities. For example, in the context of health and illness, I accept that pathogens *are*, however, I consider it beyond the realms of possibility to cleave such entities from our multiple, changeable interpretations of them. Put simply, I find the notion of objectivity problematic.

As Denzin (2009: 153) astutely points out, despite the rise of hegemonic notions of objective science, all scientific practice is historically mediated, ever changing and, ‘always partial’. From this ontological standpoint, then, I believe that it is only through engaging with the multitude ways in which people conceive of, understand, and attribute meaning to phenomena and, consequently, construct realities in their lives, that we can accept and embrace the messy, complexities of life. It is from this ontological and epistemological standpoint that I approach not only the research at hand, but the world in general, and I gladly accept my subjectivity, my emotion and my socially grounded position as both inescapable and honest (Ramazanoglu 1992: 221).

Methodologically, I am influenced by a critical phenomenological approach to anthropology, which prioritises the ‘need to attend to the many, and often highly charged, political, social, and discursive forces that contribute to life in particular settings’ (Desjarlais and Throop 2011: 93)⁸. I felt that this approach would be well suited to the PhD. Indeed, it is through such a methodological lens that we can engage with ‘what it means to be human, to have a body, to suffer and to heal, and to live among others’ (Desjarlais and Throop 2011: 88), while remaining ever mindful of the broader social determinants of such experience. Furthermore, I align myself with a progressive breed of anthropology, that of applied, public⁹, and design¹⁰

⁸ My interest in this approach was developed during my graduate level studies in social anthropology, and I attribute significance in my learning to João Biehl’s ethnography ‘Vita’ (2005) which explored the lived experiences of a socially ostracised, mentally unstable woman named Catrina, through an analytical lens which considered the human cost of ‘economic pressures, pharmaceuticals as moral technologies, the public consensus that lets the unsound and unproductive die’ in Brazil’s cities.

⁹ ‘Public anthropology engages issues and audiences beyond today’s self-imposed disciplinary boundaries. The focus is on conversations with broad audiences about broad concerns... Public anthropology seeks to address broad critical concerns in ways that others beyond the discipline are able to understand what anthropologists can offer to the reframing and easing - if not necessarily always resolving - of present day dilemmas’ (Borosky 2000).

¹⁰ Spearheaded by people like Wendy Gunn and Ton Otto, also Tim Ingold. Design anthropology is a new field of inquiry that has emerged which aims to integrate the strengths of design thinking and anthropological research (See *Design Anthropology: Theory and Practice*).

anthropology, which acknowledges that ‘the world of anthropology keeps changing’ (Hannerz 2010:1). With each iteration slightly distinct from the other, these new and developing anthropologies nevertheless share the goal of going beyond the traditions (and traditionalists) of the discipline, taking anthropologies to a wider audience by means of interdisciplinary and extra-academic collaboration, and methodological innovation (This Anthropological Life, 2016). Ethnography, as both a practice and a product, is arguably no longer the property of the anthropological academy alone. With the adoption and adaptation of traditional ethnographic methods to different settings, ethnography has evolved, an evolution that is both exciting and progressive. This conviction that ethnography can benefit other fields is what led me to apply for this PhD research, which I understood as seeking to apply ethnographically-informed practice to a very modern, local research field.

Having reflected on and summarised my position as a researcher, I now turn to address how I prepared for the field, beginning with a period of acculturation at the facility which was invaluable in planning a feasible research project at this site (Maxwell 2012: 66).

3.3 Acculturation: Getting to know the field-site

Conscious that I would struggle to plan a feasible research project at the field-site without prior understanding of how the social world of the clinic functioned, I engaged in several ‘fact finding’ and acculturation activities during the first year of my PhD. These included a period of informal observations at the facility and a small survey of ‘walk-in’ attendees to gauge the feasibility of their inclusion as participants. In this section, I discuss each of these activities, reflecting on how the experiences informed my research practice.

I was able to engage in a period of observations at the facility, in the hope that this exposure to the life and rhythms of the clinic would help me think through the logistics of my research. This observational period was supported by senior staff at the facility. In February 2013, following clinical governance approval from the Quality Improvement Team (Appendix 1) at the facility, and in possession of an Honorary Research Contract, I spent a week (4th-8th February) observing triage and reception staff, learning how intake at the facility worked, and building rapport with staff members, upon whom I would rely to recruit attendees (detailed below) once my research started in earnest. I also spent time in the menopause (13th February)

and IUC (20th February) clinics, as well as following senior cover staff¹¹ on their mornings in the general clinic on two occasions (15th and 20th February). In April I spent further time at the facility, this time attending health advisor sessions (19th April), a further senior cover session (16th April), the Gay men's clinic (17th April), the HIV clinic (11th April and 15th April) and No-talk testing (18th April).

The time spent at the facility, getting to know the field-site, was invaluable. Pragmatically, it allowed me to conceive of a feasible study and helped me gain confidence in my ability to conduct the research. It also exposed me to the language, social order, social actors and the logics of the space – all of which, despite being 'at home' and familiar in some ways, were simultaneously intimidating and strange. I got to know staff members and, importantly, they got to know me. Our informal interactions were formalised during the informed consent process (to be discussed). While none of the observations made during this time of acculturation are presented in any explicit sense, they nevertheless informed my understanding of the field-site and gave me the confidence required to conduct fieldwork competently within this social setting.

Once I had made the decision that I would like to include 'walk-in' attendees in my purposive selection (for reasons to be discussed below), it was important to test whether, in fact, 'walk-in' attendees might be willing to participate in my proposed research. As such, I prepared a feasibility survey (Appendix 2) which outlined what participation was for, what it would entail and asked individuals to indicate whether they might consider taking part in such a study. The survey was placed in the foyer of the facility over two days and, of the 50 sheets I left, 23 came back as affirmative, meaning that the individual would take part in such a study, while 18 came back as negative. Seven selected 'I don't know' and two were uncompleted. While this test was rudimentary, it nevertheless gave me an indication that it was not unreasonable to expect some attendees would be willing to participate.

The focus of the research was to better understand attendee experiences of this particular specialist facility, and so it was necessary to employ methods that would allow for me to 'engage practically and actively with the situated and everyday practices through which built

¹¹ Senior cover refers to the practice that, at each general clinic, there will always be a consultant on duty to help in more complex cases. The practitioner sits in a small office on the clinical floor to be called upon by other HCPs if they are presented with an attendee who has complex needs, for example.

environments are used' (Lees 2001: 56), perceived and experienced. To this end, I selected ethnographically-informed methods, specifically, observations and interviews. Here I introduce the methods, before outlining how they were adapted for the field.

3.4 Situated ethnographic practice: Descriptions and adaptations

It is well established that qualitative research methods, of which ethnography represents one end of a broad spectrum, present powerful and effective means through which to learn of people's lived experiences, especially in situations where little is known about a particular topic. In this regard, the contributions of qualitative research to our understanding of people's lives are irrefutable. In this section I introduce the specific methods that I applied to the task of garnering insights into experiences of the field-site, decisions that were influenced by my aforementioned positionality. I introduce the reasoning behind the selection of each method, its strengths and weaknesses, and adaptations I made in order to make the methods acceptable, indeed feasible, to the situated context.

3.4.1 Participant observations

Since Malinowski stepped 'off the veranda' during his fieldwork in the Trobriand Islands¹², participant observation has been regarded as the established method for 'doing' ethnography. Characteristics of this method include immersive, inductive, detailed observations of social action, language, symbols and behaviour. This 'thick description' - to use Geertz's (1973) seminal phrase - is then linked to theoretical frameworks to a greater or lesser extent.

Prioritising a commitment to context, and 'emic', or insider perspectives (Sobo 2009: 71), and non-verbal registers of communication, participant observations have remained central to ethnographic practice. Yet, as ethnography has been undertaken by a wide range of social researchers, and also anthropologists working in contemporary field-sites, the methods that have defined this practice have been subject to change. This has been driven in part by an

¹² Malinowski, B., 1922. *Argonauts of the western Pacific*. New York: Dutton. Malinowski's seminal work was, later, to be subjected to significant criticism upon the recovery of his diary of his time in the field which expressed, among other things, racist views towards his participants.

increasing focus on the institutions of the developed world, rather than the distant field of anthropological tradition and the ‘primitive’ communities often presumed to reside there.¹³

The strength of ethnographic observations is that they offer a means to gain understandings of the experiences of social actors (Sobo 2009: 43; Pile 2010: 11). This is done without relying upon language, but instead focusing on, as Thrift (2004: 59) notes from a non-representational theory position, other ‘models of communication’. Observations thus have the potential (so long as the researcher notices) to capture otherwise ‘unreported’, routine and subconscious human behaviours within their context, in real time (Guest et al 2013: 81). Indeed, ‘there is a belief that in asking people how they feel they will inevitably only communicate their feelings using ‘affective false consciousness, where the “client” rehearses crass caricatures of what they actually feel’ (Pile 2010:9). Throop (2003: 235), speaking from a phenomenological anthropology perspective, emphasises the importance of examining experience at various temporal moments to capture the way in which ‘experience’ may be divided into the present/action, the anticipated, and the recounted. Depending on whether experience is being analysed in the moment, in anticipation, or in recollection, Throop (2003: 235) suggests that, as researchers, we will gather ‘pre-reflexive’ reality, anticipated experience or narratives of recollection. What this ‘temporal orientation’ means to our engagements with participants is that we must try to appreciate the entire spectrum of their experience (Throop 2003: 236).

Crucially, however, ethnographic observation is not a detached practice, with the participant observer transcending the action they witness. Indeed, as the name suggests, the individual is expected to be part of the lives of those they study while maintaining ‘enough analytical and intellectual distance to allow him or herself to undertake observations, and analyse and interpret what is going on’ (Wind 2008: 80). This inherent tension in the method means that the knowledge produced through participant observation will only ever constitute a ‘partial truth’ (Geertz 1986: 7), impacted by the researcher’s interpretive filter, and a human’s inability to notice everything (Wolfinger 2002). Thus, while participant observations offer the researcher the opportunity to ‘collect material on the context and situations in which

¹³ Contemporary ethnographic enquiry focused on the once-belittled ‘familiar’ is demonstrative of a growing intellectual appreciation of the ‘exotic of the Self’ (Long et al 2008: 71). See, for example, Gellner and Hirsch (2001) *Inside Organizations: Anthropologists at Work*.

people articulated their experience’ (Huby 1997:1152), the very collection of such observations will inevitably be subjective.

3.4.2 Participant observation to ‘negotiated interactive observations’

Participant observation has been adapted over time in response to the different settings in which it has been practiced (Wind 2008: 80). It is not my opinion that such adaptations are inevitably detrimental to the practice of participant observation. Rather, such adaptations can be seen as reflections on the need to ‘re-conceptualise fieldwork and participant observation’ (Wind 2008: 84). When it came to my own research at the facility, I was influenced by Wind’s (2008) reworking of participant observations, an adaptation that she refers to as ‘negotiated interactive observations’. Conducting ethnographic research at a rheumatology ward and a private rheumatology clinic in Denmark, Wind (2008: 81) speaks of her inability to partake in ‘proper’ participant observations, because she ‘didn’t really manage to become an active part of the on-going activities and events in the hospital setting’. The point that Wind raises here is important, for it raises the obvious question of the extent to which non-insiders can, in fact, become participants in the field. This is a question of the role that the researcher can adopt within an institution – a question that is particularly pertinent in the context of health care facilities. It has been suggested that there are a variety of roles on offer to researchers, including the patient, the staff, the visitor (Wind 2008: 82; van der Geest and Finkler 2004: 1998), as well as students and researchers (Boydell 2010; Gale 2010; Pryce 1998), as volunteer-researchers (evident in Peters et al 2001; Pulman-Jones 2001; Lawton 2000) or as researchers and staff members (Day 2007; Parker 2001). Decisions as to which role to assume must be made by the researcher prior to conducting fieldwork, and may well be determined by social actors within the setting, as well as ethical considerations and assessment. The point being made is that none of these ‘roles’ offer the opportunity to be unrestrained and immersed in the field-site. Each will result in a partial view of the social world of the clinic. Wind’s ‘negotiated interactive observations’ was instructive for me for it offered a way of conceiving of practicing ethnographically-informed research in a Western health care setting. In describing what she means by this, Wind (2008: 87) says, simply:

‘The concept of negotiated interactive observation captures what happens when you are doing fieldwork without at the same time assuming that you become one of “them”’.

The adaptation of participant observation to the context meant that my observations were not unstructured, nor immersive. In the case of both attendees and staff, observations were very much negotiated and structured around the interactions of staff and attendees as they provided or received care. Despite this structured approach, the time spent with attendees as they waited in spaces along the care pathway, and as they underwent their clinical consultation, was invaluable for the development of insights into their experiences of the facility. I was able to build rapport with attendees as we waited, observe their behaviour, such as the nervous chewing of fingernails, and witness the consultation – all insights that provided a useful point of reference for the interview and allowed for informal conversations to be had. Thus, while I was not fully immersed in the field-site, this did not impinge on my ability to ethically gain information that would answer my research questions (Maxwell 2012: 90).

3.4.3 Interviews: A space and time for participant narrative

In addition to conducting observations at the facility, I chose to conduct a single interview with each participant as soon after the consultation as the attendee wished or, in the case of staff members who engaged with participants and were willing to themselves participate, at a time of their choosing. I anticipated that the interviews would allow for participants to express their feelings, in their own words, and offer insights into the subjective meanings and interpretations that they assigned to their experiences (Rice and Ezzy 1999: 67; Patton 2002: 341; O'Reilly 2008: 125). Including interviews in my methods was also, in part, an ethical choice. I felt it was important to provide the space and time for participants to voice their own narrative of the experience, rather than relying solely upon my own interpretation of the observations I made. In this way, then, the use of interviews alongside observations also made the research more methodologically robust.

I planned for the interviews with attendees to be context dependent. During the waiting periods I was influenced by the 'go-along' method (to be described below), whereas post-consultation I prepared to conduct semi-structured interviews. The 'go-along' or 'walking' interview is an approach to qualitative research used in health studies, anthropology, sociology and geography as a method that allows the researcher to 'actively explore their subjects' stream of experiences and practices as they move through, and interact with, their physical and social environment' (Kusenback 2003: 463). The method, used exclusively among participants who might be considered experts in their own realms acting as tour guides

to researchers as they pass through neighbourhoods (Kusenbach 2003; Jones et al 2008; Capriano 2009; Garcia et al 2012), nevertheless influenced my thinking with regards to attendees to the clinic. It seemed to me that, as with those walking through their neighbourhoods, talking of their experiences, my time with attendees as they passed through the various waiting spaces of the facility would be, in some ways, a ‘go-along’, as participants and I might chat to pass the time (more on this later).

In addition to the time I spent with attendees prior to their consultation, I also planned to conduct semi-structured interviews which followed a topic guide (Appendix 3). These interviews would be somewhat determined by my research interests, and also the observations made while on the ‘go-along’, while also encouraging new, unanticipated points to be raised by the interviewee (Green and Thorogood 2013: 96). In terms of the attendees, I felt that the semi-structured format would complement the time I had already spent with attendees as they waited for their consultation, and the observations I made during this time. I anticipated that, having spent an amount of time at the clinic, waiting and in consultation, individual attendees might be keen to get on with their days and, as such, the semi-structured format was also chosen with an awareness of not wishing to ask too much of participants. In fact, however, in most instances interviews lasted an hour or more, as attendees spoke at length of their feelings, beliefs, and intimate details (O’Reilly 2008: 125-126) of their sexual experiences and practices – things that they themselves noted were private and not often discussed widely. When it came to staff interviews, again, I planned for a semi-structured format based on a topic guide (Appendix 4, and Appendix 5 for stakeholders). It was clear to me from my time at the facility that staff members were often very busy and pressed for time and, as such, I anticipated that securing interviews with staff members might prove to be a challenge. While interviews provided me the space and time for gaining insights into subjective experience, they were nevertheless subject to omissions of detail, both intentional and inadvertent, which occur through de-contextualised recounting of practice (Green and Thorogood 2004: 132; O’Reilly 2008: 160). Furthermore, interviews are contrived social interactions, imbued with power disparities between the interviewer and interviewee which can have significant influence over the knowledge that such interactions produce. As such, using them alongside other methods, such as observations, helped to strengthen the trustworthiness of my findings as to participants’ experiences of the clinic.

3.5 Ethics as a process: Step one – planning for research and ethical review

Design of the doctoral research demanded careful consideration of ethical issues. Unsure of the necessary steps to take in terms of gaining ethical approval for my research, I referred, prior to seeking ethical approval, to official guidelines set out by the Association of Social Anthropologists (ASA) and the advice given by my supervisors, management at the facility, and the Scientific Officer of South East Scotland Research Ethics Committee. I met with the Scientific Officer to discuss my methods, submitted a protocol, and completed a form pertaining to gatekeeping and personal identifiable information. Following these steps, I was determined to be conducting a service evaluation and, thus, rather than going through the local NHS REC, my research went through the university Research Ethics Committee at the Centre for Population Health Sciences. I received ethical approval from the committee in December of 2013, having successfully defended the two points of concern that they raised in relation to my application (see appendices 6 - 10). With ethical approval granted, I nevertheless knew that this bureaucratic step was secondary to what I viewed as my own responsibility to conduct ethical practice, in-situ, as situations arose and in keeping with the reality of ethics in the field. Indeed, ‘ethics is an ever-present concern for all researchers; it pervades every aspect of the research process from conception and design through to research practice, and continues to require consideration during dissemination of the results’ (Goodwin 2003: 567). Hence, in the following section I discuss the ethical considerations which influenced the planning period of my PhD. Ethical decisions made during fieldwork will be discussed later.

3.5.1 Confidentiality and anonymity: Attendees to the service

Confidentiality relates to the findings generated from research, while anonymity or privacy is related to the person (Whiteford and Trotter 2008: 53). Thus, the imperative in ethically sound research is to ensure that the findings borne of investigations cannot be attributed to identifiable individuals. When it came to planning my own fieldwork, these concerns were at the forefront of my mind.

Confidentiality of service provision is explicitly stated on the facility’s website and lies at the heart of its care provision. All attendees are provided a ‘PIN’ (patient identifier for all test

samples, lab work and results), based on the name, date of birth and address *provided by the attendee*. All of this information could be false, indeed, as Day (2007: 14) pointed out from her own research, ‘phantom names and addresses’ were often given by attendees, who were uncertain of the legal status of any information they might pass over. No ID is required to access care. While individuals are encouraged to provide a contact number or address, this is not required. A key ethical imperative, then, was to maintain this opportunity for anonymity for participants in my research. I never asked participants to disclose personal identifiable information, and indicated that they could use a fake name, or initials, on the consent form. Indeed, there was no way for me to know whether the name they signed was their own or a false name and, I would argue, this did not matter at all to the research.

When it came to the ‘walk-in’, I decided that I would attend the facility with two pseudonyms written in my notepad each day - one male, one female. When I was introduced to the participant, the pseudonym would be one or the other. For booked appointment holders, from whom I had to receive an ‘opt-in’ form (Appendix 11) prior to their participation, I was privy to some personal information such as their phone number, email and name (if, indeed, it was their real name). Yet, I intentionally paid little attention to this information, striving to know these participants in the context of the facility and, thus, by their assigned pseudonym. I felt that in this I was doing what I could to maintain their anonymity. In all instances (‘walk-in’ and booked appointment holders) I came to know my participants by their pseudonym, using this in all written field-notes, in my document files and in the transcripts. This system was so effective that, upon recently seeing a participant at a social gathering, I had to admit that I did not know what their name was – something that was amusing to the individual in question.

3.5.2 Confidentiality and anonymity for staff

While attendees who participated in my research were strangers to one another and, often, to the staff members at the facility, the same could not be said of those employed at the clinic. With only a small number of employees at the site (120 or so), it was clear to me that I would have to adapt some of the conventions of research reporting in order to protect the anonymity of staff. I decided to do this in two ways. In the first instance, all quotes from staff members have been stripped of idiosyncrasies of speech. For example, I interviewed one staff member who had a particular way of speaking that I felt would be clearly identifiable. These phrases

in the text have been removed. In addition, I have not provided much detail about the speaker, such as job title or gender, in a conscious attempt to preserve the anonymity of those who participated. This lack of attribution is not, I believe, in error for - and agreeing with Stewart (2016: xi) - anonymity indeed demands 'that individuals are not credited with their statements in the text'.

3.5.3 Informed consent

Informed consent is a vital part of conducting research. There are various means of securing it, most commonly in written form or, when this is not appropriate, verbally (Whiteford and Trotter 2008: 66). Informed consent forms for my research were designed in line with ethical guidelines set out by the ASA and BSA. They include details regarding the purpose of the research, what it would entail, who was funding the research and how the findings would be disseminated. The forms also stated that participation was voluntary and could be cut short, without prejudice, at any point (Appendix 12).

I decided, in keeping with normative ethical standards, that all potential participants in my research should 'opt-in'. This meant that all participants had to actively consent to be part of the research (Ritchie, Lewis and Elam 2003: 96). I felt that this was an important stance to take, as this would take as a point of departure an understanding that individuals are not assumed to be willing participants, while also making it easier to refrain from participation than requiring a participant to 'opt-out'. While this 'opt in' mechanism was tricky to implement at times (Ritchie, Lewis and Elam 2003: 96) (most notably with regards staff members), I believe that it was the most ethically sound approach. Pragmatically, consent was gained by means of different approaches when it came to attendee 'groups' and staff. Details of this will be provided in the 'Recruitment' part of this chapter. In addition to 'opt-in', I was keen to make it clear to all participants that they could, at any time and without reason, retract their consent and 'opt-out'. To make this as easy as possible for participants, I provided all of them with my contact information: email, landline and mobile phone number. Furthermore, when accompanying participants through the clinic, or interviewing, I sought to reconfirm consent. For example, after the consultation I asked individuals 'how do you feel about the interview?' While this may have appeared clumsy or overbearing to some participants, I felt it played an important part in cultivating an ethical relationship with them. Indeed, 'trust with research participants is established and then maintained over time.

Consent needs to be established on a regular basis, as does the right to withdraw from the study' (Ramcharan and Cutcliffe 2001: 363).

3.5.4 Ethical considerations: Observations in semi-public spaces

Conducting observations in semi-public spaces, alongside a consenting individual but surrounded by those who had not consented to take part in the research, posed a considerable ethical quandary. Indeed, Murphy and Dingwall (2007) in their study of 'informed consent, anticipatory regulation and ethnographic practice' note that it is inherently difficult to manage consent in semi-public spaces. It is not possible to gain consent from everyone in the space. During these 'casual encounters' it is vital that the researcher act ethically, making the right decisions based on the context (Murphy and Dingwall 2007: 2230). What types of decisions might be important in the context of observations in semi-public spaces, such as the waiting rooms of my field-site? Wood et al (2013: 10) suggest that the act of writing field-notes is performative and ensures that the researcher's identity is on display, allowing people to adapt their behaviour. Yet, I worried that such overt recording can have the effect of making people feel unnecessarily surveilled. Thus, I had to decide how to conduct my observations in certain semi-public spaces based upon what I felt was important to observe. I decided that, prior to being matched with a participant, I would position myself behind the reception booths, somewhat hidden from the waiting room. This enabled me to focus on the sounds of the intake and provided me with a partial view of the seats immediately in front of me, yet I hoped to prevent attendees from feeling surveilled. I used my time behind the desk at the 'walk-in' to learn about the intake processes of admission, rather than an opportunity to take notes on individual people in the waiting room. Indeed, I made it clear in my ethical review that there was little need for me to make detailed observations of the waiting room and those within – this was not necessary for the research at hand which was focused on the experiences of the clinic of those few who opted to take part. In the main waiting room I took more notes than I did when I was with participants in the 'hubs', as once in the 'hub' I was with a participant and, therefore, wanted to be available to them if they had questions or wanted to chat. I felt that sitting writing notes would disturb this.

3.5.5 Ethical considerations: Interviews

When it came to ensuring ethical practice throughout the interviews I conducted with participants, I tried to stay alert to verbal and non-verbal cues that might suggest the participant was uncomfortable (Rice and Ezzy 1999: 55). I also encouraged the participant to take control of the audio recorder, showing them where the ‘stop’ button was located and instructing them that at any point they were able to turn the device off (none of my participants did this, in fact). Of course, interviewees were encouraged not to answer any questions that they felt were upsetting or simply did not wish to respond to and they could end the interview at any time. Aware of the onus not to cause harm to participants, which can include what Whiteford and Trotter (2008: 74) call ‘psychological harm’ brought on by embarrassing questions, I refrained from asking direct questions about the consultation or presenting issue, instead asking around the topic. With some prior experience of conducting in-depth interviews with young refugees in London, and people living with HIV or AIDS and those caught up in the world of commercial sex work in Kenya, I felt that I had developed some of the competencies required to ensure the wellbeing of participants in interviews. In practice, only one attendee participant appeared upset during the interview, and yet remained keen to continue nevertheless. Furthermore, I was often surprised at the willingness of participants to discuss such intimate details with me, a subject I will elaborate on further in later chapters.

3.6 Who, how and for what reasons? Selection decisions, and recruitment logistics

The PhD position was advertised as a ‘qualitative study of service users’ experiences’ at a newly opened, fully integrated sexual and reproductive healthcare facility. The selection of my field-site was pre-determined. Reasons for why the site was chosen have been discussed in Chapter 1 and so here I address the additional decisions that I made in the first year of the PhD, as I planned to start fieldwork, before going on to discuss who actually took part.

3.6.1 Selecting attendees

The selection of participants to my study was informed by several considerations which are discussed in this section. I describe the process of selecting to whom I extended an invitation

to take part using the term ‘purposeful selection’. I avoid using the term ‘sample’ because I find it doesn’t accurately describe the methods I used. As Maxwell (2012:96) says, ‘sample’ can be problematic because ‘it connotes a purpose of “representing” the population sampled, the usual goal of sampling in quantitative research’. The selection of participants to my study was informed by several considerations, none of which was intended to be “representative”.

As noted in the introductory chapter, the facility offers a large selection of services to a heterogeneous attendee population. As such, there were numerous potential options when it came to the selection of attendees. Considering the exploratory character of the research, which would contribute to the handful of studies on experiences of integration in practice, I felt that any number of possibilities would be appropriate and might contribute to our understanding of experiences at such facilities. In order to make a decision, the principles of ‘time, people and context’ set out by Hammersely and Atkinsons (1983: 46) were instructive, as was existing integration literature discussed in the previous chapter. I decided to include ‘groups’ which would offer the opportunity to be at the facility at different times of day (‘time’), accompanying attendees with various needs (‘people’) and attending the facility for different reasons (‘contexts’). As such, my selection was purposive (Maxwell 2012: 97-99; Ritchie et al 2003), intended to provide ‘information-rich cases’ (Patton 1990: 182) that would contribute to pre-existing knowledge. After some consideration, I decided on unscheduled ‘walk-in’ attendees and booked appointment holders to the IUC clinic, the reasons for this considered further below.

3.6.1.1 Unscheduled ‘walk-ins’

Unscheduled ‘walk-ins’ were included because the walk-in is a popular access route into the facility, but one from which a high number of complaints are generated (Annual review 2013/2014). Consequently, an evaluation of attendee experience at the ‘walk-in’ offered the opportunity to uncover new insights. ‘Walk-ins’ would also present the opportunity to compare – alongside booked appointment holders - experiences of the facility based upon access point and care pathway. Put simply, how did the spontaneity of dropping in, rather than waiting for an appointment, influence experience? Finally, ‘walk-in’ attendees were included because the challenge of successfully recruiting from an unpredictable attendee population presented the possibility of testing an innovative method of recruitment. I was keen to see whether ‘walk-in’ attendees would be willing to participate, even though they

would not be offered the ‘gold standard’ of 48 hours before providing informed consent. This point will be discussed at a later stage of this thesis, for as it happened I was inundated with willing participants from the ‘walk-in’, directly countering my prediction that these attendees would be hard to reach.

3.6.1.2 Booked appointment holders

Women attending for the IUC clinic were chosen for their comparative potential, not only when considering their means of accessing the facility, but also in terms of their arrival time to the clinic, which could range from first thing in the morning through to late afternoon and early evening. Booked appointments also undergo an invasive medical procedure when they attend the facility, unlike many of the ‘walk-in’ attendees. It would also be an opportunity to investigate existing evidence from Sauer et al (2013) and Dawson et al (2000) that women seeking IUC feel heightened stigma when attending integrated services. The Scottish Government’s priority to increase uptake of intrauterine contraception provided further reason to seek insights into attendees’ views of the specialist service.

3.6.1.3 Selection of Staff

While the focus of the research was to examine attendee experiences of their time at this integrated facility, I also invited clinical and administrative staff to participate in my research. I made this decision as I felt that there would be analytical benefit to the inclusion of staff. By interviewing staff members who interact with attendees it is possible to detect similar or different, and possibly discordant, perceptions of the service (Wood et al 2013: 10). Further, and as noted by Pryce (2000) in relation to his own research at a GUM clinic, the inclusion of staff members’ views aided in his interpretation of attendee experiences and it was this observation that influenced my own decision. In the case of my own research, staff perspectives on their practices and interactions with attendees did indeed prove helpful in the interpretation of attendee experiences, most notably in terms of the consultation, as discussed in Chapter 7. In my own research, I anticipated that I would include staff members who interacted with my participants and, indeed, all of the staff who participated I had observed as they interacted with attendees in my study. In addition to the analytical benefit, I also felt that, by virtue of the ethnographically-informed methods employed, it would have been disingenuous to suggest the possibility of not being influenced in my interpretations by their presence. Thus, and keeping with the conviction that interviews provide space for those

observed to speak for themselves, I felt that it was ethically correct to provide staff members with the opportunity to take part in an interview.

3.6.1.4 *Stakeholders*

Finally, I included purposeful selection of some of those involved in the conceptualisation and repurposing/design of the facility. My intention in doing this was to provide insights into the rationale behind integration in this specific context. There were five of these participants, however, little can be said about them in order to preserve their anonymity. These individuals were, however, instrumental in directing me to relevant grey literatures – such as the standard business case for the re-provisioning of the service. One key omission was the architect involved in the re-provisioning of the service. This was a disappointing gap¹⁴, not least in relation to Martin et al's (2015) recent review of the absence of architect's voices in the sociology of healthcare architecture.

3.6.1.5 *How many to include?*

Despite the methodological preference for ethnographic studies to be approached as openly as possible, normative standards of ethical and academic review boards expect 'highly detailed protocols regarding data collection, including number of subjects, time frames and prepared data collection forms' (Sobo 2009: 71). Thus, my research was subject to this standardised practice of estimation, and I found it challenging and arbitrary in equal measure to come up with a number. Seeking guidance in this matter, I referred to the few studies of sexual health services that I was able to find, which used both ethnographic methods and interviews only, in order to inform my decision. Where numbers of participants were stipulated, the range was between ten in a GUM-based study (Mulholland and van Wersch 2007), through to 87, of which 76 were attendees, at another GUM facility (Evans and Farquhar 1996). It seemed that between seventeen (Duncan et al 2001) and 37 (Dixon-Woods et al 2001) was the most common range for participation rates. With these numbers as a guide, I decided that aiming for between 40 and 60 participants might be reasonable. However, during my first year review, I was cautioned that this number might be too ambitious for the PhD, given the volume of findings that the methods employed would generate. A revised recommendation of

¹⁴ Resulting from the architect's own exit from the process prior to the opening of the new facility, and no response from the firm that took over the project nearing its end.

between 30 and 40 participants was suggested. I took this recommendation on board, cognisant that while it would be ideal to continue until I had reached a point whereby I identified ‘the same stories, themes, issues and topics’ recurring (Bowling 2002: 381), I would also have to remain mindful of conducting feasible research within the time allotted.

3.6.2 Recruitment

Recruitment commenced at the ‘walk-in’ in January 2014 and finished when I sent out my last wave of postal invites for booked appointment holders in mid-November of that year. Throughout the recruitment process I relied upon the help and advice of staff members at the facility who, over the course of the fieldwork, were instrumental in the success of the recruitment process. Here I discuss how I went about recruiting ‘walk-in’ and booked appointment holders as well as staff and stakeholders.

3.6.2.1 *Walk-in*

Recruiting ‘walk-in’ attendees involved creative, and ethical, thinking. On account of the unpredictability of the ‘walk-in’ access pathway, there were very real practical obstacles to overcome. By pursuing ‘available encounters and events as they arise’ (Ritchie, Lewis and Elam 2003: 81), I was able to access an otherwise harder to reach population (Green and Thorogood 2004: 102; Maxwell 2012: 97). How to facilitate recruitment at the ‘walk-in’ demanded careful consideration of how to inform attendees of my research while also remaining mindful of ethical imperatives. I designed an A4 information poster that was attached to the back of the laminate triage card, which was kept in the foyer and which all attendees to the ‘walk-in’ must collect (Appendix 13). This poster served the dual role of informing all those present that there was a study underway (mentioned by Boydell 2010 as an ethical requirement in her own research of a specialist family planning service), while simultaneously serving as a means to recruit participants. Such methods of recruitment are identifiable in literature based on empirical studies (Mulholland and van Wersch 2007) as well as being referred to in methodological texts (O’Reilly 2008: 7). This poster, which included a photograph of me so that people would be able to identify me as a researcher, was informed by the guidelines of the ASA (2011: 2). These guidelines stipulate that when conducting research among ‘strangers visiting a community’, whereby consent is not practically possible given the numerous and transient nature of the population, it is important

to make individuals aware that research is being conducted, and for the researcher to make themselves known as such (ASA 2011: 2).

The poster briefly outlined what the study was about and what participation would involve. It detailed that triage would facilitate recruitment, with the triage nurses asking individual attendees if they would like to take part. This process of gatekeeping allowed triage staff to assess individual attendees' appropriateness for participation, specifically with regards to age, English comprehension and vulnerability. I worried that the nurses' status over the attendee in triage had the potential to be coercive with regards to participation. However, I was informed by more than one attendee that when asked about their interest in taking part in the research the triage staff member was decidedly balanced, this I imagine being a result of triage staff member's awareness of the impropriety of being coercive in such matters, coupled by my own assurances that they did not need to 'sell' the research to anyone: 'if people don't take part, that's a finding too'. Once an attendee had expressed an interest in taking part, I was introduced to them by the triage nurse, or reception team member. At this point, the participant and I moved through into the atrium area where I welcomed them to the study, introduced myself and explained what would happen. This included giving the attendee a participant information sheet to look over (Appendix 14). I then asked if they had any questions, and whether they felt – at this early stage – they would be willing for me to be in the consultation with them, or if they would prefer that I waited outside. I made it clear that their consent could change and be repealed at any time, without question and that I asked them at different points to verbally confirm their continued willingness to take part or otherwise. If all was well, the attendee was then given the consent form to sign (see Appendix 12). Once called in for their consultation, I, again, asked them whether they would prefer that I leave the room during any point of the consultation – keen to offer a clear 'way out', rather than asking the attendee to be assertive. Having completed the consultation, I asked each participant how they felt about continuing on to the interview stage, making it clear that they did not have to continue. Despite offering multiple chances to refrain from taking part in the interview, of the 16 'walk-in' attendees in my research, all but one (Poppy) decided to take part for the duration of their time at the clinic and in interview.

Despite this seemingly cumbersome recruitment process for the walk-in, in practice the system worked without issue from the first day of fieldwork. The role of the staff members at triage in supporting recruitment was invaluable.

3.6.2.2 *Booked appointment holders*

Recruiting booked appointment holders began as I came to the end of the walk-in recruitment. Given the conventional means of accessing the service, recruitment was far simpler than for the 'walk-in'. Using postal information packs, women were invited to take part in the study. While I prepared the contents of the packs, in the interests of safeguarding the identity of women who chose not to participate, I relied upon the support of an administrative staff member at the facility to address and post the documents. As with the triage staff, the support of this individual was invaluable for the success of recruitment. The recruitment pack included a participant's invitation letter (Appendix 15), participant information (Appendix 16), and an 'opt-in' reply slip (see Appendix 11). A return stamped addressed envelope was provided, with which those wishing to participate could return their 'opt-in' form. Finally, the information pack provided individuals with the information necessary to contact me, or an independent advisor, prior to making a decision to take part or otherwise.

I contacted the women wishing to participate, prior to their appointment, using their preferred means of contact listed on their 'opt-in' slip. I contacted the women twice – at receipt of their intention to participate and once again the day before the meeting. Women often said that they found receiving a text on the day prior to be helpful, as it served as a friendly reminder without being as intrusive as a phone call. As with the 'walk-in' participants, once I had met booked appointment participants I took time to sit with them and allow the participant to ask any questions about their participation. I provided the participant with the consent form to complete as we waited for the appointment. As was the case with the 'walk-in' attendees, women attending the IUC clinic were invited to state their preference at any time regarding my presence in the consultation room. Furthermore, and cognisant of the physical pain that the fitting of IUC can bring on, I always asked each woman whether she felt able to take part in the interview or preferred to postpone. In fact, none of the women postponed, often liking the idea of coffee and cake (paid for by me – through research expenses – although I did not make this clear prior to the interview so as not to influence the decision) as a time for simultaneous interview and recovery from the procedure.

Despite anticipating that the booked appointment holders would be easier to recruit to the study, they were in fact far more challenging than those to the 'walk-in'. My initial mail-out, at the end of February 2013, comprised 30 postal packs. From this I received only two 'opt-in' forms. A further mail-out was completed in early April, this time consisting of 40 packs and generating five responses. On my last two mail-outs, I sent 50 packs each time, from which I received a further four and two participants, respectively. As such, booked appointment holders took much longer to recruit than 'walk-in' attendees, the latter of which were surprisingly easy to recruit, despite my fears to the contrary.

3.6.2.3 Staff

Recruitment of staff demanded careful consideration. As Green and Thorogood (2013: 71) note, a 'problem for many ethnographic or participatory designs is that participants may not be recruited to the study as individuals, but as collectives, such as staff on a hospital ward'. In order to provide a rigorous and ethical recruitment process for staff members, I engaged in a number of activities aimed at informing staff members of my research and implementing a system which protected their rights to get on with their work without being included in the research, steps which I outline below. I do not suggest that I was entirely successful. Indeed, as Vivant (2002:245) reflects on her time conducting ethnographic fieldwork at a hospice in Central Scotland, she found that even staff members who had completed informed consent forms sometimes made clear statements that indicated their wavering *informed* status. She notes, (2002:245) 'I was repeatedly asked... "What is it you're doing again?"', thus clearly indicating the incompleteness of consent, what she refers to as 'detached ethics'.

Prior to starting fieldwork, I posted an information bulletin in the internal newsletter, which is widely read by staff members at the facility. This presented an effective channel through which to introduce myself and the intended research (Appendix 17). This notice also indicated that staff would receive a study information pack, including an information sheet (Appendix 18) and an informed consent sheet (Appendix 19). The information provided noted that while observations would be taking place, these were primarily structured around accompanying consenting attendees on their care pathway and, as such, I would not be interested in assessing nor making judgement on staff practice. Staff were instructed to read through the information sheet, and those who were willing to take part in the research were asked to complete the consent form and return it to a dedicated, sealed 'post box', set up in the break room for me to

collect each day. This was a tricky ‘opt-in’ consent process, given the number of staff at the facility, and I had to work sensitively to ensure ethical practice. This meant that I made a conscious decision to only observe staff members whose consent forms I had received, while remaining conscious of the possibility that ‘if one’s manager has agreed to a study it is sometimes difficult to refuse to be involved’ (Mulhall 2003: 310).

In addition to the newsletter bulletin, I also attended a ‘Protected Learning Session’ on December 17th 2013 in order to present in front of the full team of staff members and offer the opportunity for questions. Meeting with staff in this way has been noted as a mechanism for consent by several researchers (Pope 2005; Ledger 2010) as well as a Newcastle-based researcher with whom I met (*in consultation*: 07-06-2013). As it happened, the staff did not seem concerned about the recruitment process, with the only questions relating to which attendees I would be accompanying on their clinic journey. My feeling about this was that, as a teaching hospital, staff members were used to having students and researchers conducting research at the facility.

In order to avoid a situation arising whereby a consenting attendee is to be seen by a non-consenting staff member, a reception team member would mark the patient sheet of the attendee with a red sticker. This system to protect the choice of staff at the facility while research was underway was suggested by a senior staff member as being acceptable and non-disruptive to the efficiency of service provision. In practice, if a HCP did not consent to take part in the research, they would be able to identify the marker and elect to see a different attendee. This system was not expected to adversely affect the efficiency of the care pathway, as there are a number of clinical staff on duty each day, so non-consenting staff members could choose to see the attendees not participating in the research.

In the end, 12 staff members were interviewed. Far more consented to being observed in their work (some 80 or so). Unlike the introduction to ‘walk-in’ and booked appointment holders in the next chapter, those staff who did take part will remain anonymous, for reasons already discussed. Their participation was invaluable, though, and their lack of individual representation in this thesis should not belittle the time they took to aid me in my research.

3.6.2.4 Stakeholders

Recruitment of stakeholders was conducted in a snowball manner, by which I mean, I was provided with the contact information (email) for a key stakeholder by one of the lead staff members at the clinic. I emailed this stakeholder to introduce myself, and the questions that I would like to ask with regards the re-provisioning of the service. I met this individual at a café, where they answered my questions and then advised me of who else to speak to. Thus, the recruitment of stakeholders was facilitated by the individuals themselves, who referred me onwards.

3.7 Fieldwork and after

Fieldwork began in late January 2014, and continued until December 11th of the same year. During the recruitment of ‘walk-in’ participants fieldwork was intense, while recruiting for booked appointment holders and waiting for their scheduled appointment with the doctor resulted in periods away from the facility. In this section I discuss what happened during fieldwork. I outline how I approached fieldwork, what I learned and how I tackled both the recording of findings and their subsequent analysis and representation. I end the chapter with a reflection on the trustworthiness of my findings.

3.7.1 Conducting observations and the creation of field-notes

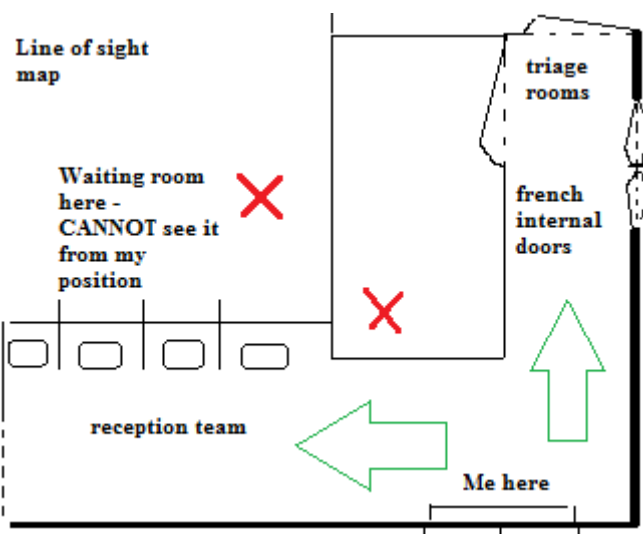
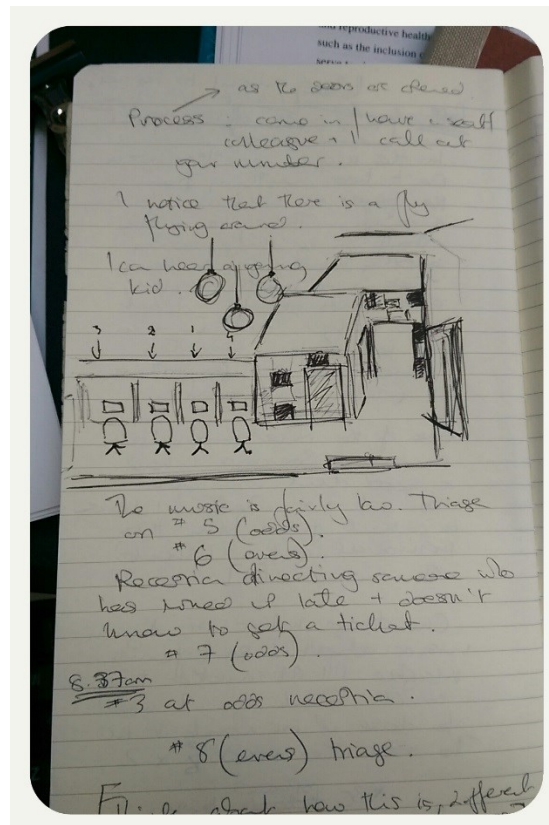
From the first day of fieldwork, I successfully recruited attendee participants via the ‘walk-in’. While I had been unsure of the effectiveness of my recruitment strategy in such a transient setting, a concern that was shared by my supervisors and staff at the facility, an attendee wished to participate every day. On several occasions, I was told that more than one attendee was willing, which, due to logistical issues, I had to refuse. The success of recruitment via the ‘walk-in’ was unexpected, and provides an interesting example of how one might go about accessing such groups. It also speaks to, and challenges, wider shared assumptions about stigma, shame and preferences for privacy that I anticipated as being a potential barrier to recruitment (discussed in Chapter 8).

In total, I spent three out of five days per week at the clinic, for five non-consecutive weeks¹⁵. My reason for this routine was to allow for two days per week to transcribe interviews, reflect

¹⁵ 27-29 Jan; 3-5 Feb; 17-19 Feb; 11-13 March; 17-20 March

upon my fieldwork thus far, and make changes to topic guides as I saw fit, in relation to what I was learning from participants. On the days that I was at the 'walk-in', I would arrive at the facility at about 7.45am and greet the staff on duty, both triage and reception team members. This was something that I enjoyed doing, while also allowing me to make sure that everyone understood their role as gatekeeper and facilitator in the recruitment process. Invariably, the staff members on duty were aware of what I was doing, but at times wished for a refresher with regards the details of the recruitment logistics, which we would discuss prior to the 'walk-in' opening.

Having greeted everyone and addressed any queries, I would then go to my position behind the reception desks (see sketches below – original from field journal and clearer version made once back at the office):



I would then wait for the 'walk-in' to start. From this vantage point, I would take descriptive field-notes, using Spradley's (1980: 78) guidelines (printed out and glued onto the front of my notepad as a reminder), which suggest taking notes of 'the spaces, actors, activities, objects, acts, events, times, goals and feelings to which I am witness'. I would not, however, make specific observations about who was in the waiting room, for reasons already discussed, and I would only take notes on staff - using their pseudonym - if I knew these individuals had

‘opted-in’. An example of field-notes at this stage is below, from my first day, on 27th January 2014:

‘Today I arrived at about 7.50am. I wanted to arrive early so that there was time to talk through the logistics of recruitment with the triage and reception. The triage opened at 8.30am sharp. My posters had been attached to the back of the laminate numbers and so, in theory, people would have learned a little about the study. In addition, the lead triage nurse announced the study at the beginning to everyone, to notify them that they might be asked about it during triage.

The walk-in opens and the triage nurse tells everyone that they will be seen by, either herself or her colleague. She then tells people with appointments to go to the appointment desk, number 3. I notice the general hum-drum of work: the sounds of the printers, the calling out of numbers, and the murmurs from the waiting room. About 15 mins passes before one of the reception team members gets up and turns the radio on. It’s really pretty loud. I notice that as they call numbers up to register, it seems that people might be having a hard time hearing as they have to call several times. The radio stays up loud. 8.45am – even triage at number 20. Even reception at number 14. 8.50am – even triage up to number 22, and so on’. For today, there were 36 spaces open. This means that 36 people could be seen in walk-in. A further 20 could be seen by NTT. The numbers are determined by the number of staff on duty each day. Each staff member can see 6 people maximum. Therefore, today there were 6 clinicians on duty today. Although the idea is that no-one is given a guarantee to get into clinic it was made clear to me by a triage nurse that the following individuals should be seen regardless of their issue: Gay men; Under 16s; LARC. For those who are not given a space at the clinic, it is possible for an appointment to be made for them. Or they will be encouraged to see their own GP. The process is that people are called into their respective triage room by the triage who call odd or even numbers. The triage nurses are paired up with a reception team member who will also be, either, odd or evens. Once called up by their yellow ticket number the individual will be triaged and, if they secure access to walk-in, they then go back into the waiting room to await being called up to register. Again, they will be called to the reception by their number. At this point they will register and be informed of the approximate time of their appointment. They are then informed to head downstairs to the hub waiting areas.

I sat in the corner of the reception area, sort of behind the triage cubicles. From this spot, it was easy for triage nurses to pop their head out and inform me if someone wanted to participate, and it was also equally as easy for the reception team members to grab my attention. However, this was also a spot from where I couldn’t see the waiting room/hear the registrations/be seen. So it seemed to be a good place.

Once I was informed by a triage staff member that I had a participant for the research, I would either wait for them to register with the reception or go directly with them through to the NTT 'hub' waiting room and then we would wait together. Depending upon their care pathway assigned at triage, participants might be in and out of the facility within an hour (as was the case with NTT) or their visit (and my time with them) might last for several hours. I remained with participants throughout, as none of the participants asked me to leave and showed no signs of distress that made me unsure of their wishes.

While some participants chatted away with me as they waited – about politics, magazines, the space of the facility, their work, their holidays, and so on and so forth – others were more reserved. I would always say to participants as we went through the formalities of the information sheet and consent form that it was up to them whether they wished to speak with me or just sit quietly. I tried to be a comfortable presence in a contrived situation and, in the main, I feel that I managed this by reading the body language of participants and handing them the reins in terms of starting, or refraining from, conversation. As we waited together in the 'hub', I would remind the participant that they could ask me to leave the consultation room at any time while also offering them the opportunity to request that I wait outside throughout. None of my participants took me up on this offer.

Up to this point in my time with the participant, I would take no notes at all. I made this decision because I felt that it might create extra distance in an already contrived interaction. Instead, I relied upon what Emerson et al (1995: 19) refer to as 'head notes. During the consultation, when the attendee and the HCP were behind the curtain preparing for the examination, I would turn these into very brief 'jottings' (Emerson et al 1995: 19; Wolfinger 2002: 87; Pope 2005: 1182; O'Reilly 2008: 73) on my notepad. This system worked well for me, and I believe that it made for a less contrived interaction, although of course the argument could be levied that in not making notes I was, perhaps, disguising my role as a researcher. In my opinion, my very presence with the individual would suffice in terms of a reminder of my status.

During the consultations, I would sit in a seat indicated by the HCP and observe the interaction unfolding between the attendee and clinician. I paid attention to the questions being put to the attendee, in addition to body language and their position in relation to one another (whether they were facing each other, or the HCP was facing their computer, for

example). I also took note of what happened, in what order and for what reasons. Again, I did not write anything down during the interaction, as I felt that this might be a distraction to me and perhaps the attendee and/or practitioner. I did not find this to be a restrictive approach to observations of the consultation, for the simple reason that I accept that, as a researcher, I will never be able to notice everything going on around me and yet, by observing keenly, rather than observing and writing, I felt that I had a better chance of remaining engaged. Once back at the office, I would then turn my 'jottings' into 'full notes' (Emerson et al 1995: 19) in which I would expand upon the observations I had made in situ. Field-notes included as much information as possible, including the descriptive, such as 'dates, times, details, and background information' (O'Reilly 2008: 73), as well as my impressions and subjective experiences of events (Carmack 2010: 1396). I made sure that in order to prevent the loss of details which come with the passing of time (Hammersley and Atkinson 1983: 146; Emerson et al 1995: 41; Mulhall 2003: 311; Green and Thorogood 2004: 145; O'Reilly 2009), I always returned to the office directly from the clinic and wrote up these extended field-notes. Of course, these notes were 'in no sense complete records of what I observed "in the field"' (Atkinson 1992: 454). They were partial records of my own interpretations. As Ryan and Barnard (2003: 100) rightly point out, 'the researcher acts as a kind of theme filter, choosing (often subconsciously) what data are important to research and what data are not. In this sense, producing field notes is a process of identifying themes'.

By the end of my time at the 'walk-in' I had accompanied 16 attendees to either NTT (3) or the general clinic (13). Participants were demographically diverse, with decades of birth ranging from the 1990s to the 1970s. Self-identified nationality included Scottish, Scottish/Norwegian, British, Polish, Indian and Welsh. One participant was unemployed, with the remainder employed in a range of occupations, such as hospitality, business, banking, creative industry, and research. In addition, a couple of the participants were students. While demographically diverse, the presenting concern for participants using the 'walk-in' was homogeneous, with only two participants (Maddie and Harriet) attending for a non-infection related issue. Of the remainder, 12 were in attendance in order to get tested for infection, either as a result of being symptomatic, or following a sexual encounter which they assessed as having put themselves at risk while remaining asymptomatic. One other participant, Garry, was seeking post-exposure prophylaxis (PEP). Finally, another participant attended in order to be pre-emptively screened for infection, prior to engaging in 'blood play'

with his partner. The following chapter, 'Interlude', introduces each of my participants in the study, both 'walk-in' and booked appointment holders.

My first participant via the booked appointment IUC clinic was on March 20th, thus overlapping with my final day at the 'walk-in'. My last booked appointment attendee consultation was on December 11th. During these 8 months or so, I accompanied a total of 13 women to their IUC clinic consultations, and here I describe and reflect upon this part of my research. Recruiting for the booked appointments was a drawn out process which, with the help of an administrative staff member at the facility, eventually resulted in recruiting enough women for me to recognise recurring themes in their narratives. Once I had received an 'opt-in' form back, I would contact the woman by means provided in order to say thank you for their willingness to participate, and to let them know that I would contact them again the day prior to their appointment in order to double check their intention and provide instructions on where to meet. I learned quickly that this text message, email or phone call the day prior was well received, as it allowed for clarity in terms of how participation would go and, thus, subdued any niggling worries about how we might find one another in the clinic and what would happen.

I would always meet the participant in the main waiting room. On some occasions, the room was empty bar the individual, and so it was easy to approach the woman and introduce myself. On other occasions, I would ask the reception team member to indicate to me when the individual had registered. This worked well. Once registered the reception team member would say something along the lines of 'Sarah is waiting for you over there' – indicating where I was standing. While the recruitment of booked appointment holders was slow, the experience of meeting them and starting on the care pathway was seamless.

As was the case with 'walk-in' participants, I would sit with the participant in the hub and wait to be called in for the consultation. Again, I would make it clear that we could chat, or otherwise. More often than not, we would talk. In addition to the 'small talk' conversation pieces that were similar to those I had with 'walk-in' attendees, women to the IUC clinic would commonly express some fears, or anxiety, about the pain involved in the procedure they were about to undergo, at times asking me whether I had experience of such procedures and, if so, how they felt. In these instances, I felt it important to be honest – indeed, participants were sharing their stories with me, and so I would tell them that, yes, I had IUC.

Yet, when it came to the question of pain, I tried to measure my response, saying that I had heard it was different for each person, and that there would be the opportunity to talk about it with the HCP.

Inside the consultation room, events would unfold in the same way as with the ‘walk-in’, in terms of my practices of observation. Commonly, the procedure which I would listen to would last between 5 and 20 minutes, depending upon how the woman felt about the pain and her anatomy (for example, how easy it was to see the cervix). During this time I would write notes down about what I could hear, who was talking with who (CSW with attendee; HCP with CSW; HCP with attendee) and what they were saying. These were details I could then pick up on in interviews, for example, asking why a woman kept on apologising for expressions of pain.

By the end of my time with the booked appointment holders, I had accompanied 13 women to their consultations. Of these, five women underwent removal of previous IUC and fitting of a new device, seven were having fittings only, and one – assigned to the wrong clinic in an administrative error – had a contraceptive implant replaced¹⁶. These women were aged between those born in 1960s and 1990s, and identified as the following nationalities: Irish, Australian, British, Scottish and Lithuanian. All of the women were employed, across a variety of sectors and roles, including management, care work, teaching, translation, childcare, healthcare (dentist, GP and physiotherapist) and business owners.

3.7.2 Conducting interviews and the creation of transcripts

After spending time with participants at the facility, I conducted the interview at a time and place of the participants’ choosing. I felt that a different location, such as a café, might provide a neutral territory for the interview that would help attendees feel more comfortable. Yet I was also aware that such public settings could feel exposed in light of the very personal conversations that might take place. Wishing to give the attendee participant the choice, I always asked their preference between ‘here, in one of the spare triage rooms, or somewhere else, a café?’ I was surprised, given the aforementioned private content of the interviews, that the majority of attendees elected for the café, rather than remaining on site. For some, there

¹⁶ A 14th participant was found to be pregnant during the consultation and, as such, the procedure could not go ahead. The consultation ended and the participant wished to leave so I did not have an interview with her.

certainly seemed an urgency to leave, while for others it was perhaps the comforting prospect of a cup of tea that was appealing. Of all of my interviews with attendees, 26 were held immediately after the consultation while the remaining 2 were arranged for a later date and time of the attendee's choosing. Two interviews were unrecorded at the behest of the participant. Finally, 1 attendee did not go on to take part in interview following the consultation.

When conducting the interviews I always began with an explanation of the types of questions I would be asking, while also stressing the point that questions could be left unanswered. I also invited individuals to raise points that they felt were important, if I did not ask them. This point was reiterated at the end of the interview, when I would say 'is there anything that you think I have missed, or something you wish to add that I haven't covered?' The topic guide was used to remind me of the questions that I was interested in addressing, while not wishing to restrict broader topics. Indeed, while some interviewees were direct in their responses to questions, others would meander – something that at times resulted in fruitful insights while, at other points, was less relevant. In addition to using the topic guide, I would also draw from observations made in the consultation, the 'hub' waiting area and informal conversation, in order to ask questions. As noted above, I was keen for the interviewee to feel that they had some control over the recording device, and so would show each individual how to use it and turn it off, placing it equidistant between them and me. As the individual spoke, I would write a few jottings down, but prioritised remaining engaged in the person's account. My responses (verbal and non-verbal) to attendees' accounts offered signs that indicated I was present in the conversation and, indeed, these expressions of listening were often involuntary, the verbal registers such as 'yeah', 'hmm' and the like only becoming apparent to me when I listened to the recording. If an individual did not understand a question and asked for clarification, I would provide it, although this did not occur often. Furthermore, I was conscious of the importance of allowing silences, while also not wishing to make the individual feel uncomfortable, thus saying things like 'it's ok, there's no rush'. My approach to each interview was to be non-threatening or -coercive, friendly, and clear in my questions. I wanted to put each participant at ease. I felt that, due to the time already spent with them in waiting, and observing their consultations, by the time of interview attendees had become more attuned to my presence. When it came to conducting interviews with attendees, I was surprised by their openness – their willingness to talk frankly about personal issues. I

considered this forthrightness to have been aided by the time I had spent with each attendee. This initial time spent together had allowed the attendee to ask me questions, to establish their level of comfort around me and to decide upon the extent to which they were willing to share their experiences with me.

Interview completed, I would say goodbye to the participant and immediately return to the office, where I would transfer the audio recording of the interview onto my desktop, test that the transfer had worked, and then delete the file from the audio recorder. I did this so as to ensure that, should I lose my recording device, there would not be any findings on it. Given the aforementioned taxing nature of fieldwork, I would never transcribe on the same day as having conducted an interview, instead listening back to the interview if time permitted (interviews were at different times of the day, sometimes running into the late afternoon), and then begin transcription the following day. I found that this break provided time for reflection on the interview, and it was during this quiet time that I would often think of links between interviews, and theoretical ideas that I would then write down in a memos notebook.

My interviews with staff members who interacted with participants in my research provided an additional component to my interpretation of attendee experiences. I approached these staff members, via email, in order to see if they might be willing to take part in an interview. During the 'walk-in', I had observed nine different HCPs in their interactions with attendees. Of these, I secured six interviews. For booked appointment holders, I observed five HCPs, of whom I interviewed three. Finally, I also interviewed three members of the reception team.

Staff members were interviewed at the clinic, at a time of their choosing. I was cognisant of the time pressures that staff members were under, and so would emphasise at the beginning of each interview that they were to stop when they wished. As with interviews with attendees, I would outline the types of questions I would be asking, while also stressing the point that questions could be left unanswered. Again, I invited staff members to raise points that they felt were important, if I did not ask them. This point was reiterated at the end of the interview, as was the practice with attendee participants. I was surprised to find that most of the staff members I interviewed were available to speak to me for more than 30 minutes. In many instances it appeared that staff members were keen to talk about integration and their perceptions of the impact thereof on attendee experience.

The process of transcribing, while time-consuming and tedious, was invaluable for my analysis. As I typed, ideas would come to me that I would put down in memos in the side-margin of the script. I also learned that there were, at times, differences in how I remembered the interview and what the transcription process revealed. For example, on occasions I felt that an interview had been less illuminating than others, yet, when it came to transcribing I would feel differently. This, as Bondi (2014: 47) reflects on her own similar experience, speaks of the very real possibility of discrepancies in the interview transcript and how I remembered the interview and, thus, indicates to me the importance of transcription as a step in analysis.

3.7.3 The end of fieldwork

My time conducting ‘negotiated interactive observations’ (Wind 2008) was characterised by spending time with attendee participants and interacting with staff members both in formal and informal spaces (so, for example, at the reception but also in the break room upstairs). Accounts and observations were documented through the writing of extensive field-notes (Emerson et al 1995; O’Reilly 2008; Maxwell 2012) which, over time, became less extensive and more focused. I found my time at the ‘walk-in’ exhilarating, as it was the first time I had conducted my own research and it was, simply, exciting. Simultaneously, however, the early days of fieldwork were exhausting and at times anxious, emotions reflected in my personal field-notes. I was particularly concerned about how to involve the staff in my research without being received as bossy, demanding, or simply a nuisance. The experience of having to become *present* in the field-site and negotiate the support of staff members was a learning process. However, these concerns disappeared as I met participants and focused on the task at hand. Each of the participants were friendly, accommodating and, ultimately, brave to allow a stranger to share their journey with them.

Fieldwork ended without ceremony or fuss. I accompanied my last booked appointment holder to her IUC consultation which, within minutes, was cut short on account of the individual having a positive result to a pregnancy test - a result she had not expected. Obviously needing time to process the information, and not wishing to proceed with the research, we went our separate ways. With that, fieldwork ended. A final point here is to say that I did not leave the field with the intention of suggesting that I had reached ‘data saturation’ in my research. This ubiquitously used term is problematic to me, in its apparent

(and oft-unquestioned) status. It is my belief that if I had remained conducting research at the field-site I would have, over time and with new participants, uncovered new insights - this, not least, linked to the developing field itself which is constantly being changed in terms of its social and physical landscapes on account of the introduction of new patient groups, new exhibitions and so forth. Yet, I felt confident that the quality of my findings were more than sufficient to contribute to present understandings of attendee experiences of integrated services, not least on account of the application of in-depth methods to the task. Thus, I agree with O'Reilly and Parker (2012: 2) that 'different qualitative perspectives have different indices for quality assurance and in this respect some qualitative approaches do not rely on saturation as a marker for sample size adequacy'.

3.7.4 Analysis and writing up

Analysis and representing my findings was the most daunting part of the research process. My research had generated a large volume of textual material which needed careful analysis and I was conscious of the imperative to tackle these materials in a systematic manner. Here I discuss the steps that I took in order to render these texts into the account represented herein.

The writing of field-notes and transcription triggered thoughts about the research, developing my thinking on the questions I was asking and what I was observing at the clinic. Thus, analysis did not just take place after the fieldwork was completed. It was conducted alongside fieldwork, with the field-notes and transcripts serving to familiarise me with my findings (Maxwell 2012: 105; Ryan and Barnard 2003: 88; Coffey and Atkinson 1996: 27). As mentioned above, fieldwork at the clinic generated a large amount of information. Keen to prevent fieldwork materials from 'piling up', a common pitfall among qualitative researchers (Maxwell 2012:104), I made sure that field-notes were typed on the day of events.

Transcriptions took longer. With all of my fieldwork materials compiled, a more intense moment in analysis began, as I left the clinic and fieldwork behind and embarked upon the interlinked processes of analysis and writing up. I found this to be a challenge, with my approach to analysis and writing characterised by messy fits and starts.

I began with an intentioned period during which I familiarised myself with my textual materials, such as field-notes and transcripts applied to each participant, in addition to listening to interview recordings (Pope, Ziebland and Mays 2000: 116). During this time, I

wrote down memos and thoughts in my notepad, but I did not engage in coding. I simply wished to get to know my findings (Bradley, Curry and Devers 2006: 1761). Having spent time doing this, I then considered how best to proceed with analysis. I chose to return to the texts I had just spent time familiarising myself with, this time coding them. My codes – or tags (Miles and Huberman 1994) - were both inductively and deductively determined, with their identification determined by *a priori* interests of the research as well as recognition of new insights (Maxwell 2012: 107; Ryan and Barnard 2003: 88, Miles and Huberman 1994: 56). Codes I identified included: ‘anxiety’, ‘knowledge of facility’, ‘risk’, ‘preconceptions’, ‘social landscape’, ‘stigma’, ‘secrecy’, ‘improvements’, and ‘responsibility’, these identified based upon ‘repetitions’ in the texts as well as materials linked to theory (Ryan and Barnard 2003: 89). In this interpretive process (Coffey and Atkinson 1996: 46) of identifying and sorting codes I was what Ryan and Bernard (2003: 95) call a ‘lumper’, that is, I would ‘minimize the differences’ in order to have piles that were representative of broader themes. My intention was to ‘mine’ these piles for more nuance at a later stage, once I had a better understanding of what was in my findings. I coded in the time-consuming mechanical way – using highlighter pens, scissors, glue and cards, an approach which Ryan and Barnard (2003: 88) describe as ‘typically involving pawing through texts and marking them up with different coloured pens’. While this took far more time than using software, I had found Nvivo generated a sense of distance from my fieldwork materials and, thus, coding in the ‘old-fashioned’ way was more satisfactory to my way of learning.

With codes identified, I found myself unsure of what to do next. Wishing to find some guidance, I decided to attend a workshop run by the Health Experience Research Group in Oxford entitled ‘Analysing Qualitative Interviews’, run on October 16-17th, 2014. This course provided me with practical guidance on the various approaches analysis and the various steps thereof which, in turn, served to build my confidence in what I had done so far, and how I might proceed.

Bolstered by the course, I returned to Edinburgh and set about organising my codes into groups, or categories. This process involved more painstaking work, photocopying, cutting, gluing and piling up all materials related to each code. So, for example, I gathered all of the material labelled with the code ‘anxiety’ onto one document, then again with each of the codes I had identified. This process, then, took me from coding of materials linked to

particular individuals (such as discreet transcripts) to the generation of documents wherein I had gathered all examples of one code, drawn from all participants' materials. Having done this, I was able to see which codes were more or less prevalent than others. In addition, I was able to see where codes I had initially identified might be similar enough to be grouped together under one larger category.

With the larger grouped categories, I then then wrote on a piece of A4 paper a list of each of my categories, with their component codes. This process gave me a clear, visual representation of the findings as I had organised them. It was at this point that I was able to see a skeletal structure to my thesis, and I decided to draw up a thesis plan, which I compiled in early 2015. Writing this draft outline, I learned that I wanted to represent participants' journey through the clinic in the text. I came to the decision to write the thesis in the way that it is presented here: from anticipation and arrival to exit.

My analysis, however, did not end at this point. Instead, as I wrote each of the findings chapters to this thesis, I returned to the interviews and field notes in order to review, again and with fresh eyes, the material. Each reading provided an opportunity for a different perspective, influenced by additional literature I had read and new ideas that had developed over the course of analysis.

3.8 Ethics as a process: Step two – conducting ethical research, situationally

As already discussed, what I refer to as 'step one' of the ethics process was a bureaucratic exercise in presenting my ethical considerations to a panel of experts who, in turn, audited my plans for their appropriateness (Hammersley 2009: 216). This is not to say that I am 'against ethics' (Hammersley 2009). Indeed, I found ethical review to be an invaluable learning process in which I was the apprentice and the panellists aided me in my plans for research. Yet, there is little escaping the removed and un-situated position of reviewers (Hammersley 2009: 212-215). Thus, in entering the field, I was acutely aware that I was responsible for making ethical decisions on a day-to-day basis and, in these decisions, I was informed by 'judgements in terms of local considerations and guidance by principles' (Hammersley 2009: 215). In fact, I faced very few obvious ethical dilemmas while conducting research. Yet, ethical decision making does not stop when leaving the field (Maxwell 2012: 87) and there

are several concerns I have in this regard. I felt and continue to feel a keen responsibility to those who participated in the research, and to those who supported and facilitate the work, to report back on my findings to these stakeholders. As such, I intend to arrange with senior staff at the facility to report back - in a format of their choice - on this study's key findings. In addition, for each of the participants in my research I informed them that I would contact them when the research was completed with the option to have access to the findings. This, I felt, was important and it was certainly the case that several attendees found this an interesting invitation. In terms of offering to send transcripts to participants *prior to* finishing research and writing up, for a process of checking, despite asking each individual (both attendees and staff) none of my participants took up this invitation. Finally, and linking to the life of research findings, I am aware that the accounts I have written - particularly of gay men who participated in my research - might contribute to negative stereotypes held by some readers, a concern mentioned by Day (2007), reflecting on her own research and re-telling of sex workers' experiences. I would, however, counter this perception by pointing out that these individuals chose to participate in my research and, often, spoke persuasively about their personal responsibility. In this respect, these individuals were acting responsibly by engaging with health services, behaviour that is notoriously lacking in other cohorts, such as heterosexual men.

3.8.1 My role in the research, and reflections on the quality of qualitative research.

'We have stories, narratives, excerpts from interviews. We perform our interpretations and invite audiences to experience these performances, to live their way into the scenes, moments and lives we are writing, and talking about' (Denzin 2009:151).

Before moving on to the findings chapters, it is important to consider what I see as two interrelated points, namely my role in the production of knowledge through fieldwork and the status of my findings. Once considered an 'objective' science, ethnography has come to accept the 'interpersonal nature of data collection' (Aunger 1995: 98) and, as such, it is now widely accepted that it is necessary to practice reflexivity in research. I believe that my findings are the result of methodological situationalism, that is, the product of 'an essentially circular *social practice* involving perceiving, thinking and acting (including languaging) beings' (Krippendorff 1991: 115-16). Put simply, my findings are borne of a partial and

‘particular interpretation of the transient world’ which I, and the participants, occupied for specific moments, as McLean (2007: 64) says of her own research in a dementia care home. The knowledge represented herein, therefore, is a co-construction. This is not to say, however, that this partial view of the situation is lacking. Indeed, and linking back to my interpretivist stance, I believe that all research is partial by virtue of research being an inherently human endeavour. As Laurier and Parr (2006: 1) note of the ‘end of representation’ (speaking from a non-representational theory position) ‘things, events, encounters, emotions and more that are unspeakable, unwriteable and, of course, unrepresentable’ are the moments of research that simply cannot be captured and reduced to textual representation. This should not, however, prevent us from seeking trustworthiness in our research endeavours. As Laurier and Philo (2006:3) remark:

‘Despite the seeming impossibility of ever fully, accurately, appropriately representing the “interiority” of one’s world to another, that is precisely what human beings cannot but be striving to do much of the time, whether friends chatting about their day in the café or, indeed, researchers reporting on what they had witnessed in the field’.

On what grounds, then, do I assert the quality of my findings? Criticisms levied against qualitative research, not least by those used to biomedical research, include regarding it as unscientific, subject to researcher bias, non-representative and lacking generalisability (Mays and Pope 1995: 109). Yet, as Mays and Pope (1995: 109) rightly suggest, there are ways to ensure the reliability and validity of qualitative findings, with the added caveat, however, that ‘all research is selective – there is no way that the researcher can in any sense capture the literal truth of events’. I suggest that my methods contribute to the trustworthiness of my findings. As mentioned, using observations alongside interviews addresses the shortfalls of each method when used in isolation. Through combining interview findings with observations, it is possible to go beyond, both, unintended or intended omission of detail on the part of the attendee and my own interpretive filter. Another point to make is that people perform. We present ourselves to one another with intention, in life as in research, this point made not least by Bury (2001: 283) in his coining of the term ‘faction’, which highlights the particular nature of what we are told by participants in research – not quite fact, but also not fiction – these narratives exist in the in-between. There is, however, a degree to which time can help in breaking down this performance. Indeed, I feel that I learned more about my participants with whom I spent lots of time than those who were in and out of the NTT care

pathway, a point I attribute to the greater time we spent together and the way in which this seemed to foster more open interaction.

Understanding that participants would have performed in response to my presence, reflexivity is important as a tool to counteract the effects. By acknowledging the limitations - that it is not possible to remove ourselves from the findings - we can think critically about our impact on our interpretations. The most pressing issue in my experience was a concern that attendees thought I worked at the facility. Indeed, it was very unusual for participants to say anything overtly negative about the care they received and I wonder whether this was, in part, because they were unsure about my role and alliances. While I tried to make my identity as a researcher clear, through the advertisement materials placed in the facility, and in conversation with participants, I am not sure that this was successful or understood in all instances. Therefore, I acknowledge that the findings I represent here are only perhaps one account among many of their experiences, by which I mean, I expect that how they represented their experiences to me might well be different from how they spoke about it to friends. My reflexivity does not solve the problem of my role in the co-construction of findings, but it offers nuance to the interpretations I offer rather than feigning 'objectivity' and making claims to 'truth'. In this way, reflexivity preserves the complexities inherent in qualitative findings, which attempts to generalize often lack (Chalkier 2011:788).

And yet, it is rare that a phenomenon experienced during research is wholly unique. Exploring recurring themes and deriving usable insights necessarily entails performing a *certain kind* of generalizability. The challenge is to put such commonalities in terms which recognize the 'doubleness of a situation', whereby 'typicalness' and uniqueness are considered equally (Delmar 2010: 121). To meet this challenge, my approach to delivering the analysis of my qualitative findings remains rich in detail, and attempts to paint vivid, situated portraits, providing context and nuance to those recurring themes which I identified, while seeking ways to link my findings to broader practical and theoretical considerations.

3.9 Conclusion

This chapter has discussed my experiences of preparing for fieldwork, selecting my participants and familiarising myself with the field-site. It then detailed the techniques I used to recruit participants, by working together with staff at the facility to preserve the anonymity

of participants. The different types of participants I wanted to include in my research necessitated a variety of recruitment strategies, ethical considerations and methodologies. I then described what happened in the field, including recruitment, accompanying participants, observations and interviews. Finally, I have reflected on my own role in the research process, the way in which this bears on my findings and the lessons we can draw from my analysis. The next chapter will begin presenting my findings.

4. Interlude

4.1 Introduction


This interlude serves two purposes, that is, to explain the care pathways that ‘walk-in’ and booked appointment holders were placed on, upon arrival to the facility and, following this, to introduce the attendee participants who took part in my research. Introductions are borne of the conversations I had with each attendee as we waited together, or during interview, and the snippets of information these conversations gave me into who each of these individual was, at the time I met them. A series of short vignettes which, in their very brevity, remind us of the limited, situated and momentary knowledge of participants, nevertheless aid in contextualising their accounts, and can be referred to for additional detail as readers read on. As Bloch, on Malinowski (Bloch 1977: 278) notes, ‘the long conversation which the anthropologist observes has begun long before he came...’ and continues on. In this way, then, the participants I met during fieldwork were similarly only sharing a moment of their lives with me and, as such, these will only ever be ‘snapshots’ of a much more complicated reality that remains beyond what is captured and re-told herein. A couple of final points to stress. Firstly, the details regarding nationality are self-identified, rather than imposed by me. Second, I did not ask for date of birth, instead decade, as I felt this detail was sufficient and would, crucially, help to preserve anonymity. For reasons discussed in Chapter 3, there will be no introduction of staff participants.

4.1.1 The care pathways explained

Access routes into the facility include unscheduled ‘walk-in’ and booked appointments. Individuals can access the service by attending in person or phoning the clinic for an appointment. In addition, referrals are made on behalf of individuals by their GPs, the police and hospitals. The participants in this research were drawn from those attending for the specialist intrauterine contraception (IUC) clinic and the ‘walk-in’, for reasons to be explained in Chapter 3. Of the ‘walk-in’ participants, some were allocated a place on the NTT care pathway, while others were sent to the general clinic.

4.1.1.1 'Walk-in': 'No-talk' testing (NTT) and general clinic

The 'walk-in' access route offers, as the name suggests, the opportunity to arrive at the facility unscheduled, without an appointment. The 'walk-in' runs from 8.30am - 10am, Monday to Friday, although access into a peripheral foyer waiting area is available from 7am, providing a discrete waiting area, as well as shelter from the inclement weather. Each attendee to the 'walk-in' must pick up a numbered triage card in order to be seen and assessed by the triage nurse. The cards also impart important information to those accessing the 'walk-in', specifying the rules of access and outlining appropriate use of the service (see below).



1

Welcome to the Chalmers Centre.

The walk-in clinic is open 8.30am-10.00am Monday to Friday for people with urgent problems. If you have picked up one of these numbered tickets please take a seat and wait for your number to be called. A nurse will call you into a triage room to assess your needs. If they decide you need to be seen today a receptionist will then allocate you a slot between 09:00 and 12:00. Do not leave the clinic until you have been given your time slot. If it is for later in the morning you might want to leave the clinic and return 10 minutes before your slot, but is worth checking how quickly things are running before you go away.

If an urgent walk-in slot is not required the nurse will explain how best to get an appropriate appointment either with your GP or in the clinic if that is needed.

If you need to be examined in any of our clinics you will be offered a nurse chaperone. You can also request a nurse chaperone at any time. Please specify this on your registration form.

If you are here for STI tests ONLY and are at low risk of HIV and syphilis please note:

If you have NO SYMPTOMS and your LAST EPISODE OF UNPROTECTED SEX WAS AT LEAST 10 DAYS ago you may be suitable for our No Talk Testing Clinic.

Turn over for details of our 'No-Talk' STI testing clinic

As the information on the numbered card outlines, those who have attended the 'walk-in' are called up, one by one, for triage ('number 1 please', 'number 2 please' and so on and so forth), their numbered card serving as 'place markers of the ordinal sequence' while also preserving anonymity in the public space of the waiting room (Day 2015: 170). Once inside triage, the healthcare practitioner (HCP) asks each attendee to outline their reason for attending. Based upon what the attendee says, weighed against resource allocation considerations, the HCP will make one of three decisions. Providing that they can say 'no' to a list of questions outlined on the reverse side of the laminate triage card, asymptomatic attendees will be placed on the NTT care pathway (see below).

'No-Talk' Testing Clinic

This clinic is not suitable for everyone so please look at the questions below. If you can answer 'NO' to all the questions and you ARE OVER 18 YRS OF AGE you may be suitable for No Talk Testing. If you answer yes to any of the questions we will advise you about which clinic would suit you better.

- I have symptoms (e.g. unusual discharge or bleeding, pain passing urine, pain in the testicles, pain in the lower stomach, genital lumps or ulcers, etc)
- I have had sex with someone who has been diagnosed with an STI
- I have had sex with someone who has HIV or hepatitis
- I am a man who has had same-sex partners (i.e. I am gay /homosexual/ bisexual)
- I am a woman who has a male partner who had same sex partners
- I have been sexually assaulted (raped)
- I have injected drugs myself or had sex with someone who injected drugs
- I have had sex with someone from a country outside the UK, Western Europe, North America, Australia and New Zealand.
- I have at some time paid or received money for sex

Please remember you need to wait at least 10 days from when you last had unprotected sex (window period) before having the tests. The window period for some of the tests can be even longer (up to 3 months).

In the No-Talk Testing clinic –

- A healthcare assistant (HCA) who will take some blood from your arm. You will then take be asked to take a vaginal swab (women) or a urine sample (men) yourself The HCA will give instructions.
- We test for the infections Chlamydia, Gonorrhoea, Syphilis and HIV
- You must phone for results on an automated phone line in 1 week.

Please note that in this clinic you won't be examined. Health questions cannot be answered and you can't have anything else done (e.g. pregnancy test, get the contraceptive pills).

Thus, and as the name suggests, NTT offers individuals considered to be at ‘low risk’ with the opportunity to be screened for four of the most common STIs – gonorrhoea (GC)¹⁷, chlamydia (CT)¹⁸, HIV and syphilis - without having to undergo a consultation. The care pathway is intended and thus designed to be speedy, with each attendee allocated 10 minutes with the HCP.

Symptomatic attendees will also be assessed in triage in order to ascertain whether their presenting issue is appropriate to the specialist service, or whether it can be dealt with in primary care. If the presenting issue is assessed as appropriate for an ‘urgent walk-in slot’, then symptomatic attendees will be placed onto the general clinic care pathway, although and as with the case of all attendees to the ‘walk-in’, availability is contingent upon resources on any given day. There are those attendees, however, who will be given a place, regardless of constraints on the service. These priority, or ‘emergency access’, places are offered to: people living with HIV, women seeking IUC, men who have sex with men, and particularly vulnerable attendees, for example, those who have been raped.

Once triaged, the attendee either returns to wait in the main waiting room again until they are called up by the reception to register (as is the case with those assigned to general clinic) or they are directed downstairs to ‘hub’ 1 to wait for NTT, without the need to register. Those who are not provided with a space at the clinic on either care pathway are sent away. Crucially, it is only through acquiescing to triage that ‘walk-in’ attendees are able to pass through into the regulated spaces of the facility and access the service that they request.

4.1.1.2 Booked appointment holders

Unlike ‘walk-in’ attendees, booked appointment holders do not have to go through triage, instead accessing the facility by making a pre-arranged appointment. In order to make an appointment, it is necessary to phone a dedicated phone line, at which point the phone line operator will offer possible appointment dates. It is not uncommon for there to be a wait of at

¹⁷ Gonorrhoea (GC) is a bacterial STD ‘caused by the bacteria *Neisseria gonorrhoeae* and has a inflammatory discharge from the urethra or vagina’ (www.cdc.gov, 2014)

¹⁸ Chlamydia (CT) is ‘A common sexually transmitted disease (STD) caused by a bacterium. Chlamydia can infect both men and women and can cause serious, permanent damage to a woman's reproductive organs’ (www.cdc.gov)

least a month for the IUC clinic. Booked appointments for the IUC clinic can be in the morning, afternoon or evening.

Arriving at the facility, booked appointment holders are required to present to a member of the reception team who will then instruct them to pass through the doorway between the main waiting room and the atrium beyond, on the other side of which is a specialist waiting room for appointment holders to the IUC clinic (among other specialist services). For booked appointment holders, then, arriving to the facility involves a much shorter period of waiting in the main waiting area prior to being seen by staff and placed on the appropriate care pathway, this also noted in Day's (2007: 17) observations at the GUM clinic, wherein 'it was the 'walk-in' patients who had to spend hours in the clinic [while] in appointment clinics, by contrast, patients often waited only a few minutes'.

Having described the care pathways that participants in my research were placed on and experienced, I now turn to introduce these attendees, starting with those who attended the 'walk-in'.

4.2 Attendees to the 'walk-in'

Louisa, Polish. Born in the 1980s. Worked in hospitality. Identified to HCP in consultation as heterosexual.

Louisa attended the facility on the recommendation of her GP who was unable to help her with her request for a consultation about long-acting reversible contraception, this being on account of Louisa having an unspecified medical condition that made choosing LARC complicated. Louisa noted that she had never been to any type of sexual health facility prior to on the day that I met her, yet she was not at all nervous, instead saying that she was grateful such services existed. Louisa was placed on the general clinic care pathway on account of her desire to speak to someone about the possibility of being fitted with IUC, coupled with her presentation as symptomatic for possible infection or thrush. Louisa underwent a full sexual health screen and was diagnosed as having thrush. For this reason (due to the associated discomfort of the fitting), Louisa was given a booked appointment at a later date to be fitted with IUC.

Danny, Scottish. Born in the 1980s. Worked in a hotel. Identified to HCP in consultation as gay.

Danny attended the facility on the day that I met him because he recognised in himself the symptoms of gonorrhoea (GC) infection. Danny told me that he was a regular attendee at the clinic, this on account of viewing himself as ‘high risk’, because of his sexuality and engagement in sexual activity he considered risky. Danny appeared to have a complex relationship with the facility, regarding it as a place of support and non-judgemental staff while simultaneously finding the presence of other attendees difficult at times. On the day that I met him, Danny was placed on the general clinic care pathway, given a full sexual health screen and diagnosed and treated for GC. Danny was also sent to see the health advisor, where he was encouraged to talk about his feelings with regards his infection history, and invited to participate in contact tracing. Throughout our interactions, Danny referred to the clinic as ‘the GUM clinic’.

Jimmy, British. Born in the 1990s. Worked as a labourer. Identified to HCP in consultation as heterosexual.

Jimmy came to the facility with a friend (who had driven him from ‘outside town’ and waited for him as he was seen, and indeed as he took part in the research). Jimmy believed that he had contracted Chlamydia (CT), having been experiencing symptoms, and so attended in order to be tested and, if necessary, treated. Jimmy, who said he had been to this clinic in the past as well as services targeted specifically at ‘young people’, appeared very laid back and unconcerned about being at the facility on the day that he took part in my research. Presenting with symptoms, Jimmy was placed on the general clinic care pathway and was diagnosed and treated for CT.

Stuart, Scottish. Born in the 1970s. Unemployed. Identified to HCP in consultation as gay.

Stuart attended the facility alone, in quite an anxious state, believing that he was going through sero-conversion, a belief born of a recent anonymous sexual encounter and the onset of a ‘stiff neck’. Stuart was a regular attendee at the facility, where he would undergo HIV testing on a regular basis. Prior to integration, Stuart had attended the now closed GUM service across the street and did not appear to see any difference in the locations in terms of care offered. Once triaged, Stuart was placed on the general clinic care pathway. In consultation, Stuart was counselled by the HCP, who knew him, and felt that his anxiety was getting the better of him. He was, however, offered a rapid HIV test in the afternoon, after we

parted ways. Stuart, like Danny and others referred to the facility throughout as ‘the GUM clinic’.

Libby, British. Born in the 1990s. Undergraduate student. Identified to HCP in consultation as heterosexual.

Libby attended the facility alone, seeking help in diagnosing what might be causing her to have painful sex over the past few months. Libby had not wanted to wait to see her GP, so decided to attend the ‘walk-in’ instead. This was not a decision taken lightly, for Libby clearly associated the facility with ‘bad things’, such as STIs. Due to her presenting issue of pain and discharge, Libby was placed on the general clinic care pathway at triage. As we waited together, Libby appeared nervous, biting her nails and saying very little. Libby was diagnosed with thrush, and provided with a treatment cream and pessary. Referring to the facility as an ‘STI clinic’, Libby was clearly very embarrassed about having to attend.

Maddie, British. Born in the 1970s. Researcher. Identified to HCP in consultation as heterosexual.

Maddie was one of only three ‘walk-in’ attendees who did not have suspected infection and were, instead seeking IUC only. Unhappy at the wait for a booked appointment to the IUC clinic, and experiencing painful periods, Maddie decided to access the facility through the ‘walk-in’. It was clear that Maddie found the experience of the ‘walk-in’ to be upsetting, saying that she had ‘cried’ when she saw the numbered triage card that she was expected to pick up (see Chapter 5). Maddie was placed on the general clinic care pathway and fitted with an LNG-IUS.

Harish, Indian. Born in the 1980s. Worked in financial sector. Identified to HCP in consultation as gay.

Harish attended the facility in order to be seen by the HCP because he was experiencing an all-body rash. This coupled with his history of having unprotected sex with a friend made him decide to get a full sexual health screen done. Harish had been to the facility once before, a year prior, and having only recently arrived in Edinburgh from India. Previous to that he reportedly had never attended any type of sexual health facility. Saying that the first time he attended he felt embarrassed and self-conscious, on the day that I met him Harish was very open, and said that he did not find it at all difficult to attend such a facility, attributing his

change in outlook to living away from India. On account of his symptoms (the rash) coupled with his disclosure at triage of his history of unprotected sex, Harish was placed on the general clinic care pathway where he underwent a full sexual health screen. In addition, his rash was examined, and determined to be an allergic reaction, rather than anything of greater concern.

Penny, Scottish. Born in the 1980s. Worked as HCP in the city. Identified to HCP in consultation as heterosexual.

Penny believed that she had genital herpes and so decided to attend the ‘walk-in’ to get diagnosed. Penny knew about the facility because she had trained in medicine a year or so prior and so had been aware of the specialist remit of the facility at that time. Her preference was to attend somewhere with specialist staff, rather than her GP surgery. Penny had been to the facility once before, to get the strings for her IUC checked, and made a distinction between feeling responsible then and feeling embarrassed on the day that I met her, thus making a distinction between ‘responsible’ family planning and irresponsible sexual health scares. With symptoms of genital herpes Penny was placed on the general clinic care pathway and saw the HCP who confirmed that she did have the virus.

Holly, Welsh. Born in the 1990s. Undergraduate student. Identified to HCP in consultation as heterosexual.

Holly, a first year undergraduate student, attended the facility by means of the ‘walk-in’ because she had recently had unprotected sex and believed that she had put herself at risk of possible infection. Holly had never attended a sexual health facility before, and found out about the clinic through a friend, before looking it up online to gather further information on it. On the day that I met her, Holly was placed on the NTT care pathway, because she was asymptomatic and did not report having had sexual relations with ‘high risk’ individuals (IDUs, people with HIV, individuals from certain regions of the world). Her NTT consultation took longer than most, because the HCP could not draw blood from her arm, and tried her hand before making the decision to stop. Holly was, nevertheless, in and out of the clinic within an hour, which she said had impressed her.

Joe, British. Born in the 1990s. Undergraduate student. Identified to HCP in consultation as gay.

Joe, an undergraduate student, attended the 'walk-in' so as to get a full sexual health screen after having had unprotected sex. He said he felt that he should get tested, in order to be responsible for himself as well as for future sexual partners. Joe had been to the facility once before, for testing, and so knew about the clinic and the way the 'walk-in' worked. Joe's 'general clinic' consultation was mid-morning, during which time he was provided with a full sexual health screen before being encouraged to go on and see the health advisor. Joe did not take up this offer.

Roisin, British. Born in the 1980s. Worked in financial sector. Identified to HCP in consultation as heterosexual.

Working in the financial sector, Roisin attended the facility in order to be tested for chlamydia (CT), at the behest of her boyfriend. She did not appear to consider herself at risk - her episodes of unprotected sex being a long time ago, and, according to her, all but forgotten. Roisin had never been to a facility like this before, only indicating that when she was a teenager she had been to Brooke services for 'condoms'. Roisin found out about the facility through her boyfriend, who had been before. Attending asymptomatic, Roisin was placed on the NTT care pathway on account of her low-risk status. Her NTT consultation was quick and Roisin said she was pleased to see that she was able to take her own swabs.

Garry, Scottish. Born in the 1980s. Worked in retail. Identified to HCP in consultation as gay.

Garry, who worked in retail, attended the clinic along with a friend - also seeking out testing services. He attended the 'walk-in' on a Monday morning, following engaging in sex he considered to be risky at the weekend, as it was the speediest option. He did not realise that he could have gone to A&E sooner. It is unclear how Garry found out about the service. He said he had never previously been to any testing facility. Garry wanted to be given post-exposure prophylaxis (PEP) and did not leave until he had successfully negotiated this with the HCP. Following his time in the consultation, Garry was sent on the health advisor in order to talk through the implications of PEP treatment, and to arrange the follow up appointments he would need to attend.

Samuel, British. Born in the 1980s. Unemployed. Identified to HCP in consultation as 'fluid' (but at the time was with a female partner).

Samuel, who was unemployed at the time I met him, attended the clinic on his own in order to get tested for various blood-borne infections, prior to engaging in 'blood play' with his partner. Samuel had never had tests done before, but did attend the integrated facility for on-going specialist services. Samuel was placed on the general clinic care pathway and was seen by the HCP in consultation and the health advisor. Samuel was, perhaps, the most explicit among participants in his rejection of the social stigma associated with sexually transmitted infection and sexual preferences and practices, presenting himself as a responsible, active health consumer.

Poppy, English. Born in the 1980s. Researcher. Identified to HCP in consultation as heterosexual.

Poppy attended first thing in the morning for NTT having had unprotected sex a couple of weeks previously. She said she had never been to NTT before, but had attended the clinic once prior for an undisclosed reason. Triage placed Poppy on NTT, for she presented asymptomatic and her passage through the clinic was so fast that I spent very little time with her waiting. The time that we did spend together was spent with Poppy discussing how she worried about the undetected infections among the Edinburgh population, as she felt it was the minority who got themselves tested. Poppy was the only participant not to call me back in order to participate in the interview.

Heli, Scottish/Swedish. Born in the 1980s. Social care. Identified to HCP in consultation as heterosexual, 'mainly'.

Heli attended the 'walk-in' in order to see a HCP on account of persisting symptoms that she thought were, either, indicative of thrush or a STI. Heli had never been to this facility before, but had been to clinics in other cities in Scotland as well as in Sweden. On account of her symptoms, Heli was placed on the general clinic care pathway, with an estimated time with the HCP at 11am. Heli was disappointed when her 'slot' with the HCP was delayed by some 30 minutes, and her frustration appeared to create some frustration in her experiences. During the consultation Heli was provided with the full sexual health screen in addition to an intimate examination and smear test.

Harriet, British. Born in the 1970s. Worked in financial sector. Identified to HCP in consultation as heterosexual.

Harriet came to the clinic in order to get her IUC fitted. Not wishing to wait for a booked appointment, she expanded that the 'walk-in' was a preferable option. Harriet said she had been to this facility before on multiple occasions, as well as being a previous attendee at the 'stand-alone' family planning service. Harriet was by far the most outspoken of my participants when it came to her distaste for being around those she constructed as 'other' - the people attending for STI testing services. Harriet felt that the admission process was illogical and disliked greatly having to wait in the foyer of the facility.

4.3 Attendees to the IUC clinic

Marianne, Irish. Born in the 1980s. HCP in the city. Identified to HCP in consultation as heterosexual.

Marianne was the first of my booked appointment holders. Attending with her baby, having recently given birth, Marianne wished to be fitted with the LNG-IUS for her post-pregnancy contraception. Marianne had never been to the facility before, but knew of it on account of being a HCP working in the city. During her consultation, Marianne asked me to look after her baby - something that she said was a consideration in her decision to participate in my research. Marianne exuded a 'no fuss' approach to the visit to the clinic, and this, coupled with her baby being present perhaps explains the brevity of our interview together.

Jennifer, White. Born in the 1970s. Dentist. Identified to HCP in consultation as heterosexual.

Jennifer attended the facility in order to get her LNG-IUS replaced as the one she had had reached expiration date. Jennifer knew about the facility because she had previously attended the 'stand-alone' service, thus, with integration she had simply moved to this facility. Jennifer came across as busy - speaking of how it was 'impossible' to get time to attend the service, what with juggling her kids and her work.

Antonia, Scottish. Born in the 1980s. Worked in childcare. Identified to HCP in consultation as heterosexual.

Antonia attended the clinic on the recommendation of her GP, who could not fit her IUC. Antonia was seeking IUC, but did not know which type she would prefer - hormonal (LNG-IUS) or copper (Cu-IUD). She had never been to this facility previously, nor any other sexual

or reproductive health service, always preferring her GP surgery. Antonia, nevertheless, spoke at length about how important she felt facilities such as this were. Like many of the other women I spent time with at the clinic, she seemed pressed for time on account of juggling life tasks.

Ania, Scottish. Born in the 1970s. Allied health professional. Identified to HCP in consultation as heterosexual.

Ania attended the facility in order to have her Cu-IUD changed. She had been a long-time attendee to the ‘stand-alone’ service, prior to integration, and appeared to regard it as one and the same service, simply in a new site. Ania’s appointment was in the evening and she was in and out of the facility within 20 minutes, which she regarded as incredibly quick and convenient. Ania said she was not interested in having children and, therefore, felt that the availability of contraception that suited her lifestyle was a great privilege.

Lucille, Australian. Born in the 1970s. Freelancer. Identified to HCP in consultation as heterosexual.

Lucille came to the facility in order to get her Cu-IUD replaced. Like Ania, Lucille had been a long-term attendee at the ‘stand-alone’ facility and learned of the move to the new clinic when she phoned up for an appointment and was redirected. Lucille noticed a difference between the two facilities, in terms of their materiality, and showed a preference for the older site. During her consultation, in addition to getting her IUC replaced, Lucille was referred to a specialist in order to investigate fibroids she had had for some time.

Kasia, Lithuanian. Born in the 1990s. Worked in hospitality. Heterosexual (disclosed in interview, rather than consultation, which I was not able to attend).

Kasia attended the facility in order to get IUC following the birth of her first baby who, Kasia said, had been ‘unplanned’. New to the country, Kasia did not know about the facility until her GP recommended it to her, booking her appointment on Kasia’s behalf. I was not able to sit in on Kasia’s consultation, despite her consent, because the HCP in question did not wish for me to be present. Waiting outside, the consultation was fairly quick and Kasia seemed pleased, saying that she hoped it would mean she did not have another baby without planning.

Pippa, Scottish. Born in the 1970s. Small business owner. Identified to HCP in consultation as heterosexual.

Pippa attended the facility with a booked appointment, although there was a mistake: she was wanting to get her implant removed and replaced, rather than wanting IUC. This administrative error meant that she had been subject to the longer wait for IUC, when compared to the waiting list for implants. Yet, Pippa was cheerful and did not appear to be put out by this mistake. Attending with her niece, who was also going for the same procedures, Pippa's consultation was over within 15 minutes. Having attended the 'stand-alone' service for more than fifteen years, Pippa saw a difference in the clinics, more distinctly than any other participants in this research. Yet, she did not view the new facility more or less favourably, instead just acknowledging what she knew to be the broader remit at the new site.

Georgia, British. Born in the 1970s. Worked in management (unspecified). Identified to HCP in consultation as heterosexual.

Georgia came to the clinic in order to get her Cu-IUD replaced. She wanted to get this done by someone with expert skills, as she had been through a painful fitting in the past and experienced dizziness following the procedure. So, Georgia chose to attend the specialist facility, rather than her GP surgery. Georgia's medical procedure to replace her Cu-IUD was particularly complicated and took some 15 minutes - longer than any other procedure I had been privy. Despite being in pain, Georgia said little during the procedure and thanked the HCP profusely for persevering in the fitting.

Ivy, British. Born in the 1960s. Worked in financial management. Identified to HCP in consultation as heterosexual.

Ivy attended the clinic on the recommendation of her GP, who was unable to fit her with IUC. Like some of the other women at the facility, Ivy had not heard of the facility before attending. Wishing that she could get the procedure done at her GP practice, where she knew the nurses, Ivy was a little disappointed at having to come to the new clinic. That said, she was positive about the experience in general. Ivy clearly experienced the procedure as very painful - making audible exclamations of pain during the fitting - something that she appeared to be very embarrassed about, and felt the need to apologize to the HCP for.

Rosa, British. Born in the 1980s. Teacher. Identified to HCP in consultation as heterosexual.

Rosa was referred to the facility by her GP, who could not fit her with IUC. Rosa had recently given birth and was keen to get LARC, but had not decided on which type (LNG-IUS, or Cu-IUD) prior to her appointment. Hoping for the HCP's input in her decision-making on this issue, Rosa found that when the decision was handed to her alone, it was difficult to make, saying in interview that she would have liked to have followed the HCP's recommendation.

Ingrid, British. Born in the 1970s. Care Worker. Identified to HCP in consultation as heterosexual.

Ingrid was referred to the clinic by a surgeon whom she had seen on account of her endometriosis. It had been recommended that she get LNG-IUS. Ingrid was extremely quiet throughout our time together, and in consultation. She appeared nervous. Her consultation did, however, appear to go well and Ingrid expressed hope that it would help her endometriosis symptoms settle.

Jules, Scottish. Born in the 1970s. Management. Identified to HCP in consultation as heterosexual.

Jules was referred to the clinic by her GP. She wanted to get her LNG-IUS removed and replaced, as her current system had reached expiration. Jules spoke about being very nervous about the procedure – the pain involved, specifically – this fear informed by previous experience of a painful fitting at the 'stand-alone' service she had attended in the past. Her anxiety about the procedure was exacerbated by her lack of knowledge of the new facility, which she had never attended before and knew very little about.

Roz, Scottish. Born in the 1970s. On maternity leave from unspecified job. Identified to HCP in consultation as heterosexual.

Roz, like Marianne, had recently given birth and was seeking IUC. She was new to the facility, having been to the 'stand-alone' service in the past. Roz did not appear concerned or anxious about the consultation and procedure and, in fact, her time with the HCP was one of the quicker interactions, without any problems. In interview, Roz said that she was pleased with her experience at the clinic.

Keeley, Scottish. Born in the 1980s. Occupation unspecified. Identified to HCP in consultation as heterosexual. *Consultation, and participation, cut short on account of positive pregnancy test*.

Keeley was the last participant in my research. She attended the clinic in order to get an LNG-IUS. Sitting together waiting for her consultation, Keeley explained how she had never been to the facility before, but had been advised of it by a friend. We waited only a few minutes together before Keeley was called in to the consultation. Almost immediately, the HCP asked the standard question about pregnancy and issued a test, which came back positive – to Keeley’s surprise. With this new information, the consultation ended, as did Keeley’s participation.

5. Beginnings

5.1 Introduction

This chapter is about beginnings. It discusses the starting point on all attendees' journeys towards the clinic by first considering what factors, or 'triggers' (Zola 1973), led them to engage with the facility. In this first part of the chapter, we will see that most attendees' decisions to attend the facility are influenced by what has been referred to since the 1970s as 'health consumerism' (Lupton 1997: 373). This 'consumption of health care qua commodity' (Lupton 1997: 374) results from a range of factors, including: perceived risk and desire to manage risk; perception of limited alternatives; preference for specialist over generalist practitioners; preferences for speedy admission; and past positive experiences¹⁹. Attendees were influenced by the views and opinions of those in their social networks, including family and friends, in addition to their GPs. Put simply, their decision to attend this clinic was the result of often highly complex 'multifarious interrelationships between individual and social factors' (Gillespie 2002: 214). This chapter then moves on to consider how attendees experienced the clinic in anticipation of their arrival. As a result of popular understandings of the clinic, and of memories of past visits or expectations of the still unknown clinic – what Milligan (1998), writing from a social interactionist perspective, calls 'interactional past' or 'interactional potential', respectively – the facility is constructed, and experienced by each of the attendees.

Having reflected on motivations for attending the facility, followed by discussion of attendees' experiences in anticipation of arrival, the chapter then attends to the early stages of the clinic journey itself by examining how attendees experienced Gesler's landscapes (1992) of the facility's 'frontier' (Mattingly 2010) as they transited through, en-route to the consultation. Through attendee accounts, I suggest that, while the journey is brief, both in terms of the distance covered and the time it takes to traverse, it is nevertheless experienced as significant by many, most notably by those attendees who were temporarily held in the foyer prior to entering the main waiting room.

¹⁹ While I present the findings under categories, it is nevertheless important to note that, often, attendees had over-lapping reasons for attending and, as such, 'straddle' the categories I present herein.

5.2 Part One: Why attend?

Attendees often spoke of their feelings arising from the prospect of attending the facility, and the emotions experienced in the days, weeks or months (common in the case of booked appointment holders) prior to arriving at the facility. These ‘future experiences imagined’ (Milligan 1998: 2) will be retold in Part Two. First, I turn to consider the ‘triggers’ – the ‘how and why’ questions (Zola 1973: 677) – which brought attendees to the conclusion that they needed, or wished, to attend a clinic and why they decided to attend this clinic.

5.2.1 Attending to risk

All but one of the attendees in my study were motivated to pursue a consultation with a HCP as a result of risk awareness linked to past or anticipated sexual activity. For those who had engaged in unprotected sex, or sexual activity which they had concerns about, it was risk to self – of being infected – that featured in attendees’ explanatory narratives. At times, this ‘*dis-ease*’ (Pryce 2000: 107) about self was accompanied by an explicitly stated desire to learn if one might be contagious to others. For women hoping to secure IUC, unintended pregnancy was the risk to be avoided, or managed until the time that they saw fit to try for a baby. Taken together, then, it is evident that attendees were engaged in a form of ‘body maintenance’ (Nettleton 2013: 34) in their decisions to engage with HCPs. More specifically, and as will now be discussed, this maintenance was linked to risk of being infected, risk of being infectious, and risk of unintended pregnancy.

5.2.1.1 *Risk of being infected*

The following narrative excerpts from interviews show how concern over the possibility of being infected served as a motivator for deciding to do something – namely, to seek out and undergo ‘health procedures’ such as screening and tests to ‘double check’ their health status (Nettleton 2013: 34).

Of all of my participants, Stuart and Garry appeared the most concerned by the possibility of being infected. Stuart was particularly heightened to risk, specifically risk of HIV infection. Sometimes struggling with ‘the drink’, Stuart said he would have anonymous unprotected sex while drunk and would sober up with fleeting, worrisome memories. As a gay man who engaged with sexual health services on a regular basis, Stuart’s risk perception, I suggest, was

almost certainly influenced by public health messages that convey the risks involved in such activities. Despite his HIV negative status, Stuart's decision to seek testing services was triggered by the appearance of symptoms he interpreted as sinister:

'Because the neck stiffness, which is one of the symptoms you see with conversion (*yeah*). Erm...whether that's made up in my mind or, which I don't think it is, but that's me and my mind, erm... we just need to wait n' see'.

Stuart's lay knowledge of physiological signs of possible HIV infection was instrumental in his help-seeking behaviour. He understood that this symptom – the stiff neck – could be a sign of HIV sero-conversion²⁰ and, perhaps due to his 'wider milieu, such as ... cultural context, personal biography and social identity' (Nettleton 2013: 35) as a gay man with a history of engaging in risky sex, was prone to interpret the symptoms as dire.

Garry, who had had sexual contact with someone he knew to be HIV positive on the weekend prior to attending the facility was extremely anxious about his potential exposure to the infection. Seeking out post-exposure prophylaxis (PEP), Garry attended the clinic in order to give himself the best chance of not contracting the virus:

'It was, like, well I have to go and get it. I hated that I had to wait over the weekend'.

Danny, a young man who worked in hospitality, was also very risk aware. As was the case with Stuart (although not Garry), regular attendance to sexual health services formed part of his routine for staying healthy:

'I am gay and I do have anal sex. I am at high risk. And the HIV period is always three months of bloods and, as I said to you earlier, there was a point when I didn't always use condoms. I was when I first moved here and stuff, but it was about two years ago when I was seldomly using them so I made sure to come every three months, just to make sure I am STI free and stuff'.

Danny's comment about attending on a three-monthly basis hints at his pre-emptive regime of surveillance – 'just to make sure I am STI free and stuff' – another example of testing for health, as opposed to searching for illness. On this occasion, however, the motivation to attend a clinic was coupled with the appearance of symptoms that Danny understood to be

²⁰This is understood as 'the period of time during which HIV antibodies develop and become detectable' (NAM Aidsmap)

indicative of gonorrhoea (GC) infection. Danny, thus, interpreted his symptoms and decided that he required diagnosis and treatment. What is particularly interesting about his comment is how he seems to have adopted the public health message about being gay, and being at ‘high risk’ of infection: ‘I am at high risk’. As Nettleton points out, ‘notions of risk, identity and lifestyle are inherently interlinked’ (2013: 35) and Danny’s comment is indicative of this point.

While Stuart, Garry and Danny were seeking help because they held concerns for their own health, Roisin sought out testing services at the behest of her boyfriend, this despite displaying a distinct lack of concern for her own health:

‘My boyfriend wanted me to [get tested] because I have had previous sexual partners without, um, what’s the word, ugh, condoms (*yeah*) and, erm, he was concerned that I might have chlamydia and therefore couldn’t have babies because there were no symptoms to check otherwise’.

Referring to her boyfriend as a ‘hypochondriac’, Roisin did not consider herself to be at risk of infection, despite having had unprotected sex in the past. She did not identify with public health messages about testing and, consequently, had been delaying getting tested:

‘Everyone always says you should get checked but I’ve always thought, ‘probably not, I’m fine’. Erm, boyfriend asked me back in January so I’ve been *actively* putting it off for two months’ (*ok*).

Roisin did not regard herself as being at risk of infection. While Stuart, Garry and Danny were perhaps influenced in their actions by public health messages aimed at gay men and MSM, Roisin’s complacency could well have been the result of her own, culturally mediated risk awareness. As a middle class, white female in a long-term relationship the risk of chlamydia (CT) infection from her past sexual encounters did not appear to resonate. Consequently, Roisin’s decision to attend the facility for NTT was less about acting upon her own concerns but, rather, those of her partner who was worried about infection lying undetected and possibly causing infertility. Thus, in attending for testing, Roisin effectively positioned herself as doing it for him – an altruistic act, as she saw it:

‘Well, for me it was just to ease his fears (*yeah*). Erm, yep, I mean, I don’t know why – maybe I’m just cocky – but I’ve never been concerned that I have got anything (*uh-*

huh) although, you know, you can have something without any symptoms at all, but, you know, I've never been concerned'.

There are a couple of things to say about Roisin's story of attending the facility. In the first instance, Roisin's decision to get tested, despite her own lack of concern, is reminiscent of what Lupton et al (1995) found in relation to the symbolic meaning of HIV antibody testing. In their study, Lupton et al (1995: 176) learned that getting tested (and being able to prove that you were HIV negative) was 'an act of affection and commitment to a relationship'. While Roisin was not concerned about her health, she nevertheless embarked upon the testing for the benefit of her boyfriend, an act that could be interpreted as a sign of commitment. The other thing to point out is that Roisin (and others who attended NTT), despite being assessed by the institution as at a very low risk, was nevertheless tested for not only CT and GC but also HIV and Syphilis. In Roisin's case, then, both she and the HCP considered there to be a lack of identified risk, yet both participants in the consultation went ahead with the full spectrum of tests. Roisin, referring to herself as 'cocky' about her sexual health, was unusual in her blasé presentation. Her confidence or, more specifically, her display or self-presentation of confidence and lack of concern was not shared by others.

5.2.1.2 *Risk of being infectious*

For Stuart, Garry, Danny and Roisin, seeking out testing services was a response to becoming aware of the potential risks associated with their own actions and/or symptoms, albeit understood to differing extents. In other instances, attendees' stories spoke explicitly about concerns over being infected but also *being infectious to others*. Having had unprotected sex with a stranger, Joe felt that it was his responsibility to be tested, as the following dialogue suggests:

J: 'I thought I could be exposed to an STI, or like HIV and I just wanted to make sure that I'm safe. So I just needed to come in and be...responsible'.

S: 'Yeah. Now tell me a bit more about the idea of being responsible'.

J: 'Well, I knew I wasn't safe and that it was really stupid of me and I thought, well, what if I do end up with another partner and expose them? So it's best that I do just know myself what I've been exposed to, if I've been exposed'.

For Joe, a young man who worked in retail, the idea of looking after himself and thinking about others seem to be interwoven concerns. The risk that Joe had put himself in, and which he now viewed as ‘stupid’, had potential significance beyond himself. As a consequence, Joe wished to be tested not only in order to be responsible for his own health but also the health of others. In this way, we see that Joe was acting upon an understanding of ‘sexual danger’, whereby possible infection (‘contagion’) demanded diagnosis and treatment (‘purification’), an echo of Douglas’ (1984: 3-5) discussion of ‘sexual danger’ as a form of pollution belief. In their exploration of the three ways in which the body may be viewed, Scheper-Hughes and Lock (1987: 24) delineate the phenomenological, social and political body, while making clear that each of these perspectives is interrelated, ‘boundaries between the individual and political bodies become blurred, and there is a strong concern with matters of ritual and sexual purity’. In Joe’s case, his desire to do right for himself *and* society became distinct but closely related perspectives on his own body. Further, Joe’s self-chastising tone, whereby he refers to his behaviour as ‘stupid’, hints at his interpretation of his role in the situation – the risk of infection he faced was self-inflicted, as opposed to externally imposed.

Samuel also took the decision to get tested because of concerns around risk of infection *and* being infectious, in relation to his girlfriend. The couple had decided that they wanted to engage in ‘blood play’²¹, specifically using needles to pierce one another as part of their enactment of intimacy. Having attended a peer-led information session around the risks of blood borne virus transmission involved in the practice of blood play, and with past experiences of unprotected sex with both men and women, Samuel said he had felt compelled to get comprehensive testing prior to engaging in the practice with his girlfriend:

‘Erm...currently, or in terms of like my past experience, er I would say I’m mostly at risk of the fairly low, low classification things like, I don’t know, chlamydia or, you know, the, the, the less daunting ones I guess. Possibly as well HSV1. Er, I don’t *think* I’ve ever been at risk of gonorrhoea or Syphilis or HIV (*uh-huh*) and I’m pretty sure I’ve never been at risk of hepatitis either, but in terms of what I want to do in the future, I need to make sure that I haven’t got any of these things’.

While Samuel’s concern about being infectious may be less explicitly stated than Joe’s, his decision to get tested was nevertheless the result of discussion with his girlfriend – ‘we

²¹ Defined as ‘cutting the surface of the skin with sharp objects, generally a knife, for the thrill, sensation, or pain’. (Differentequals.com, n.d)

wanted to get tested together’ – and was presented in our conversations as borne of a desire to ensure that what he was planning to engage in would be as safe as possible, for both him and his girlfriend, in another example of Lupton’s intimacy as mentioned in Roisin’s case. In both Joe and Samuel’s examples, we see that there is a sense of responsibility expressed, a responsibility to known others (a partner, for example), the wider public as well as the self. They, and surely others in the research, were attending the facility as ‘selves in relation’ (Hallowell et al 2003: 74; Hallowell 1999: 613), by which I mean to say they were attending not as autonomous, unrelated beings but as deeply related and interconnected people. This sense of doing the right thing refers to an internalisation of the impetus in contemporary public health on individual responsibility to ‘avoid health risks for the sake of his or her own health as well as the greater good of society’ (Lupton 1993: 429). While Joe is acting post-event, he is nevertheless motivated by a desire to avoid the risk of infecting others in the future²².

5.2.1.3 *Risk of unintended pregnancy*

While risk of infection, and feelings around responsibility to self and others, governed the actions of about half of the attendee participants in my study, for the remaining attendees it was the risk of having an unintended pregnancy that drove them to seek out a place to get contraception, in this case IUC.

Ania was in need of a new intra-uterine system (LNG-IUS) as her existing one had reached its expiration date. Ania did not want to become a mother – ‘I’m not interested in having children’ – and so her engagement with family planning services in the past was a means to preventing pregnancy from occurring. For Ania, the LNG-IUS was a means of controlling what she regarded as the risk of unintended pregnancy, allowing her to live the life she chose without having to think too much about it – ‘I don’t have to worry about it for a long period of time, so that suits me down to the ground’.

²² Following the result of the High Court judicial review, on 2nd August 2016, which has ruled that NHS England is responsible (rather than individual local authorities) for the commissioning of Pre-Exposure Prophylaxis (PrEP) (Bhiva.org, 2016), the debates around responsibility will, inevitably, change, expand and foster new discussions.

Antonia, unlike Ania, did wish to have a child, but she also wanted to be able to plan for this future pregnancy. The survivor of domestic violence, during which time she became pregnant, Antonia had recently found herself in a happier, safe relationship and had hopes for a baby, as the following excerpt from my field-notes indicate:

Antonia said that she wanted to get the IUC because she forgot things easily and didn't want to get pregnant again without planning. She has just started to see a new guy who she really likes, and who treats her nicely, 'kindly' as she said. She wants to 'do things properly this time round', having had an abortion following a period of domestic abuse [01-05-2014].

Both Ania and Antonia's comments speak about the convenience of IUC – not having to think about, or remember, to take the pill or use condoms, for example. Taking this further, it is possible to see that this convenience is also linked to a sense of empowerment, whereby the IUC enabled women like Ania and Antonia to feel in control of their fertility.

The selection of accounts above point to the role that risk perceptions played in attendees' decisions around seeking out health care, be it testing or IUC. It is clear that, in seeking medical help, attendees engaged in their own form of risk assessment, whereby they made 'calculations about probable futures in the present followed by interventions into the present in order to control that potential future' (Rose 2001: 7). This is not to say that their decisions were autonomous. I suggest that their decision-making process were informed by the established norms of wider society which, in our contemporary neoliberal era, focus on individualised (and often gendered) responsibility (to be further discussed in Chapter 9).

5.2.2 No other option

As already mentioned, women seeking IUC appointments can be seen to be acting upon a desire to prevent or regulate the risk of pregnancy. However, what was it that brought these women to this clinic specifically? In many cases, the answer is that the facility proved the only option available. Structural barriers, namely, GP surgeries being unable to carry out the procedure, or the closure of 'stand-alone' SRH services which women might have previously attended, meant that they were often referred on by their practice, or advised to approach the clinic directly.

Gem had recently given birth to her second child and was wishing to regulate her fertility for the time being. She had been to her GP surgery to speak with her doctor about contraceptive options, while simultaneously asking the advice of girlfriends and her sister in her attempt to make her decision, in an example of what is known as ‘lay referral systems’ (Freidson 1960). With the influence of both expert and lay input, Gem came to the decision that a LNG-IUS would be the best option for her. Gem returned to her doctor who informed her that they would not be able to fit the device and that she should visit the specialist clinic. As Gem recalls:

‘I was actually in the appointment, they showed me the website for [it]. They showed me where the form is and where the video is and they said that they could refer me but it would be better if I just did it myself (*ok*), so, um, I agreed to do that’.

Gem had never heard of the clinic prior to being informed of it by her doctor. Furthermore, she had never been to a specialist facility, instead using her local surgery as her source of contraception. Despite this habituated practice - demonstrated here by the fact that she approached her doctor in the first instance for her LNG-IUS - Gem heeded the advice of her GP and booked an appointment for herself at the specialist clinic, actively looking up the website introduced to her by her doctor and reading up on the service.

Gem’s experience was not uncommon as a number of women wishing to get IUC were required to attend the clinic because their own local surgeries could not offer the service to them. Some of these women, like Gem, did not feel too much concern over the prospect of attending this new facility, however, for others, including Ivy, it was more of a worry.

Ivy said she wished that she could have her procedure carried out at her local GP surgery:

‘I would prefer it probably to still be at my doctor’s because there’s a really lovely nurse there who looks after me, and you can get that “hi, how’s you, how’s the dog, duh-duh-duh”. And I just really liked her. She was the nurse that booked me in when I first moved up here, and did my initial check. And you know that way sometimes you just really click with someone, and we had such a good laugh... I suppose it’s just that because you feel so comfortable, you can build that relationship up’.

As the above narrative suggests, Ivy’s relationship with her local practice nurse resulted in her feeling a little nostalgic when she learned that she would have to go elsewhere for her IUC. Like Gem, Ivy had never heard of the clinic before her doctor had informed her of the place.

As a result, Ivy was conscious that she would not know the people there, and might not get the ‘how’s the dog, duh-duh-duh’ that made her visits to her local surgery so ‘comfortable’. In other words, Ivy predicted unfamiliarity and lamented somewhat what she saw as a loss of continuity in her care. With this said, and as will be elaborated on throughout the thesis as Ivy’s story develops, her preference for her local surgery and the familiarity that went with it did not, in fact, translate to a wholly negative experience of the new, specialist clinic.

The structural barrier faced by Gem and Ivy was that their GP surgeries were unable to carry out the procedure they wished for. This was a result of the fact that their GP surgeries either had no qualified doctors to carry out the fitting or did not have high enough demand for offering the procedures. Indeed, there is training at the new facility for doctors from primary care in order to help ‘skill up’ practitioners so that an increasing number of women would be able to be fitted with IUC at their local surgery. Coming back to structural barriers that influenced women’s decision-making with regards to attending the clinic, we see that the closure of local ‘stand-alone’ SRH services was key, as some of the women who used to attend this service found themselves without an alternative option.

Lucille had set out to get her Cu-IUD replaced, phoning her usual family planning service to make an appointment. Upon calling, Lucille found out about the move to the new location – ‘I phoned them to make an appointment and they said we’re not actually here anymore, we’re over at [the new] centre’. Lucille said that news of the move and learning that she would have to go elsewhere did not cause her to feel much concern, viewing it as a means to getting what she needed, if at a different location. That said, in almost the same breath, Lucille spoke of a certain attachment to the old ‘stand-alone’ service:

‘Ummm, I didn’t mind, I mean I quite liked the, the other one ‘cause it’s in [place name], which is nice and it’s just in a block of almost, you know, a block of other flats and it’s just got a really nice, you know, sort of familiar feel about it (*uh-huh*) so...I just thought it was a shame it moved’.

As Lucille’s account shows, despite starting by saying that she did not mind the move, she also used the word ‘familiar’ to speak of the former family planning service, implicitly juxtaposing the stand-alone facility with the new and unfamiliar integrated service. This is somewhat similar to Ivy’s reaction, however, for Lucille rather than speaking of the familiarity and comfort of a specific staff member, she instead focused in on the materiality of

old versus new – ‘it’s just in a block of almost, you know, a block of other flats and it’s just got a really nice, you know, sort of familiar feel about it’. Indeed, this familiar feel was almost certainly attributable to the fact that the previous ‘stand-alone’ service that Lucille referred to had been housed in a ‘lovely Georgian house, reminiscent of a home, rather than a clinic’, as one practitioner described it. Lucille’s focus on material space and its affect introduces in many ways a central vein of the thesis, that ‘a place is *remarkable*, and what makes it so is an unwindable spiral of material form and interpretative understandings or experience’ (Gieryn 2000: 471).

While Gem, Ivy and Lucille came to the facility as a result of structural barriers, making them what Lipsky (2010: 54) refers to as ‘non-voluntary’ other attendees actively sought out the specialist clinic, above and beyond other options (usually their local surgery). This consumerism could be regarded in the individualised framework of ‘place dependence’, defined as a concern with ‘how well a setting *serves goal achievement* given an existing range of alternatives’ (*own emphasis* Jorgensen and Stedman 2001: 234). While this speaks of rational, individual autonomy in decision-making that has been criticised by social constructivists when considering health seeking practices, it is nevertheless the case that – in these examples – there does appear to have been a degree of consumerist practice in play. Indeed, strategic decision-making did, it seems, govern action as most of these attendees chose the new clinic over others as a result of consumer preferences for speedy attention, specialist over generalist care, and past positive experiences.

So far I have considered reasons for attending the facility as linked to the desire to manage risk and the lack of alternative services available. I now consider the reasons given by individuals specifically in relation to preferences for immediate and/or specialist care and, for some, the desire to return to a service they had previously experienced positively.

5.2.3 Time

Libby, a young student who had been experiencing pain during intercourse for several weeks, came to the decision that she would rather visit the ‘walk-in’ at the clinic than wait for a GP appointment, having been encouraged by her boyfriend to ‘get it sorted’. Having finally decided to attend, in an example of what has been categorised as ‘a kind of temporalizing of symptomatology’ (Zola 1973: 683), Libby found that the wait time for an appointment at her

local surgery was too long and took to the internet in order to find a more suitable, and speedy, option:

L: 'Well, like, I rang to get an appointment like and they were like we can give you one in like two weeks and so that was annoying'.

S: 'That was at the GP?'

L: 'Yeah, so I was just like, I'll just go to the 'walk-in' (*yeah*) and hopefully get seen there sooner'.

There are two things to say at this point. Firstly, Libby's use of the internet, in order to find out about the integrated clinic, instead of having to wait for a GP appointment, was not unique to her, as will be discussed later on. Secondly, Libby's view that the clinic was the best option for her was not a decision taken lightly and nor was it necessarily an easy decision in some respects. Libby was extremely embarrassed about having to attend the facility – a facility she associated with 'bad things – STIs and all that'. Considering again the concept of 'place dependence', Libby's example demonstrates that 'strength of association is not necessarily positive... each option may be negative, the chosen option may simply be the best among poor alternatives' (Jorgensen and Stedman 2001: 234). This issue of the restrictions on choice came up again in Maddie's story.

Maddie also came to attend the clinic as the result of weighing up options available to her, in relation to her desire to get her heavy bleeding and pain dealt with as quickly as possible:

'I just felt like it'd got worse, more acute in the last three weeks, corresponding with not feeling great and feeling very tired and just I guess got to a point where I wanted to take action and *I wasn't willing to wait another five, six weeks for that* 'cause it's impacting on our family life...so it was just kind of really just getting to a point where I had to do something'.

Maddie's narrative, which clearly shows her imperative to get her symptoms seen to sooner rather than later, also speaks of a temporalizing practice: having to wait beyond what has already been decided upon seems impossible to do. In addition, Maddie also refers to the interpersonal impact of her own pain and discomfort on her family, suggesting another 'trigger' for attending the facility, namely, 'the occurrence of interpersonal crisis' or 'the *perceived* interference of an illness with social or personal relationships' (Zola 1973: 683).

Due to her GP surgery being unable to help and the booked appointment waiting list of six weeks, Maddie had seen the ‘walk-in’ as the best option, if begrudgingly:

‘Didn’t have a choice (*uh-huh*). I don’t think I had a choice. Well, I had a choice to live with it and potentially have worsening symptoms for another five, six weeks (*uh-huh*), or yeah I didn’t fully feel I had a choice’.

Maddie continued:

‘I mean part of me thinks, do you know what there’s a lot of services in the NHS that you wait a lot longer for and I accept that, erm, but with acute symptoms I don’t think you should have to wait that long’.

Maddie’s comment about how, in the context of her acute symptoms, she should not have to wait for her preferred booked appointment resonates with the observation that Strathmann and Hay (2009: 220) make when they suggest:

‘When patients are told that they cannot get an appointment within the desired...timeframe, it is like being told that their health, and by extension, they as persons, are less important than bureaucratic schedules’.

Feeling somewhat put out by the wait for a booked appointment, Maddie made a pragmatic decision, rather than one she felt entirely pleased with. Further, Maddie’s comment about not wanting to wait as long as she would have to for a booked appointment points to the tension that Lipsky (2010: 38) refers to as the ‘demand-supply dilemma’ of street-level bureaucracies, including health facilities. Indeed, queuing, either in first-come, first served systems or on waiting lists characterises the ‘costs’ faced by the public as a result of their growing expectations of health care in a context where demand outstrips supply (Lipsky 2010: 95; Melville et al 2004). So, in Maddie’s case, the fact that she had to wait for a preferred booked appointment resulted in her paying the price, so to speak, at the ‘walk-in’.

5.2.4 Specialist over generalist

The preference for speedy care, expressed by Libby and Maddie, was not the only rationale given for deciding to attend the clinic over GP surgeries. Another significant wish was to seek out the specialist over the generalist, linked to attendees’ trust in certain forms of expertise over others. Unlike Libby and Maddie, to whom ‘place dependence’ came with a

price – potential loss of face (Libby) and generalised feelings of inconvenience that developed into feelings of not belonging (Maddie) – for others, ‘place dependence’ was positive, as they positioned the clinic above, or better than, other options available. They believe in the value of specialist care and, therefore, actively sought it out.

Georgia decided to come to the clinic for her IUC because she believed the care would be better than at her GP surgery:

‘Well, I came here because the coil that I had fitted five years ago was due to be renewed and I know someone who recommended that I use here rather than my GP because they are tricky things to fit and the doctors here are doing them all the time. So, if there’s a problem, I know...that they can be dealt with whereas if you’re at your GP they’re not used to fitting them. It can be a bit of a hit or miss’.

Georgia’s comment points to her desire to have her ‘coil’ (Cu-IUD) taken out and replaced by someone who had regular experience of carrying out the procedure, in contrast to her doctor – ‘my GP’ – whom she knew did not have the opportunity to fit the devices often. The result was that Georgia felt comforted by the idea of regularity of practice. In this respect, Georgia was not alone, as other attendees also indicated a preference for practitioners who carried out certain procedures on a daily basis. Further, Georgia’s story, in a similar way to Gem’s, points to the influence of the advice of others – in this case her friend – who had encouraged her to attend the facility rather than her local surgery. These lay referrals and their resonance among attendees is something that came up in a number of attendees’ narratives around their reasons for attending, pointing to the power of social networks in influencing decisions.

Louisa, unlike Georgia and others, noted that she did not have friends to help inform her decision to attend the clinic. Instead, like Libby, Louisa used the internet to find out about the clinic. Technological advances now permit people to do as Louisa did – ‘the click of the mouse on the “net” to find out information on virtually any health issue’ (Nettleton and Hanlon 2006: 62), and indeed health *facility*. As a result of her online research, Louisa made the decision to attend the specialist facility, based upon her understanding of it being the best option – thus electing the specialist over the generalist:

‘I wanted to receive competent service from people who really know what they did. It is a sexual clinic so I thought that it will be a good place for me, not just the simple GP, just a sexual clinic – it is something what they do every day, so they know more than simple GP. That is [why] I wanted to come here’.

Louisa makes the most explicit distinction between primary care and the clinic in her dialogue, by saying she wanted to see ‘people who really know what they did’, rather than ‘just the simple GP’. Louisa had been structurally constrained by the fact that her GP surgery felt unable to advise her on her contraceptive options due to an unspecified gynaecological condition, and, as a result, she did not have many other options open to her. That said, Louisa’s decision points to very clear preferences for specialist care and, in this sense, speaks of a consumerist tendency to ‘shop around’ and find the best possible option. While it is clear that Louisa did approach her GP surgery in the first instance, this may well have been as a result of not knowing about other options available to her. Once she had learned of the specialist facility it seems she was drawn to their expertise, as she perceived it.

5.2.5 Past positive experience

While some attendees to the facility came as a result of structural barriers, and others sought out the best option available to them for the care they required, still others were informed by their past experiences with the facility. These individuals, like those engaging in ‘place dependence’, were making consumer choices to *return* as a result of their ‘interactional past’ with the facility. Unlike those engaged in ‘place dependence’, however, those returning were acting more as emotional consumers of health, based upon past experiences of the facility. As Casey (2001: 688) points out, ‘place comes into us lastingly, one having been in a particular place for any considerable time – or even briefly, if our experience there has been intense – we are forever marked by that place...What lingers most powerfully is this presence and... *how it felt to be in this presence*’.

For Joe, who we met earlier, his first visit to the facility – a year prior – had been better than he had anticipated:

‘It was quite scary but the nurses were really nice and it was all new and modern and so I was like, “ah, ok, it’s not too bad”. You just kind of get on with it’.

Joe’s ‘interactional past’, or memories of the nurses being nice and the new building, rather than ‘some *dingy* old hospital with dust’, meant that he felt better about attending the second time, when I met him. Not wishing to visit his GP surgery for testing, Joe decided to return to the specialist service, informed by his past experience:

‘It’s quite a, a welcoming atmosphere and it’s not like a judgemental thing, it’s like a “we’re here to help you” kind of thing’.

‘Atmosphere’ was a word that came up in several of the attendees’ narratives around their experiences of the facility and, therefore, will be discussed throughout the thesis as we travel through the clinic with them. At this stage, it is perhaps useful to introduce atmosphere as a *‘je ne sais quoi* perceived by the felt body to a given space’ (Griffero 2014: 6). This understanding of atmosphere being something intangible, ‘an ill-defined indefinite something, that exceeds rational explanation and clear figuration’ (Anderson 2009: 78) is nevertheless – as Joe’s example above demonstrates – often given definitive expression, through words such as ‘non-judgemental’.

Danny, as we know, attended the facility regularly and so when he recognised that he had symptoms for GC he did not think to attend anywhere else. In this sense, Danny, as with a number of other attendees, was place attached – he had an emotional bond with the facility resulting in a ‘lack of substitutability’ (Milligan 1998: 7). Danny admitted feeling ‘comfortable’ at the facility and, having attended every three months since the facility opened, was behaving in a way that indicated this attachment – it was a place where he could make sure that he was ‘still healthy’. Despite having positive experiences of the staff at the facility, saying, ‘they’ve treated me well, they’ve treated me with respect – they’ve not judged me’, Danny’s relationship with the clinic was complex, most notably because of his feelings about being surrounded by other attendees, a point to be discussed in the next chapter, ‘Admission’.

In this first part of the chapter, I have discussed how attendees came to the decision to, first, seek out the advice of a HCP and, then, come to attend this specialist facility. More often than not, attendees made an active choice to attend the facility, for reasons linked to aforementioned preferences and motivations. In this active seeking out of services, we see a selection of people who could be described as ‘consumers’ of healthcare. Yet, while the decision to attend does indeed suggest a level of assertive decision-making among many of the attendees, as they progress through their clinic journey we see an emergence of the active-passive (to be discussed in later chapters).

5.3 Part Two: Anticipatory Experiences

Having considered the reasons why attendees came to the decision to attend the clinic, this chapter moves on to look at how the clinic was experienced in anticipation, specifically, how attendees described feeling about the prospect of attending the clinic and what considerations influenced these emotions. As Stimson and Webb (1975: 26) pointed out in their study of patient experiences in anticipation of, during, and following their visit to the doctor, ‘anticipating the encounter may begin long before the person is seated in the waiting-room. It is, in fact, difficult to divorce this anticipation from the decision-making involved in perceiving a problem as an appropriate one for the doctor’s attention’. Once a visit to the clinic was on the horizon, memories of being there before, memories of places viewed as similar, of procedures or, in the case of some, the uncertainty of the unknown, all served to fuel emotions linked to anticipatory experiences.

5.3.1 Belonging

For those attendees new to the clinic, in the anticipatory period prior to attending, feelings relating to belonging emerged. Gem, who we know came to attend the clinic as a result of her GP being unable to fit her LNG-IUS, said that while she had few reservations about attending the new facility, she did not feel that she would necessarily belong:

‘Um, it seemed quite sort of aimed at young people who are looking for sexual health and family planning type advice’.

As a mother in her early 30s, Gem saw a generational difference between those that she presumed the facility was aimed at – ‘young people’ – and herself. As such, she did not particularly relate to the facility in the run up to attending. When asked about why she felt this way Gem mentioned the ‘healthy respect slogans’²³ on the website as formative in generating her preconception of the facility as a place for people younger than her. In much the same way, Jules, who was another woman who had been a previous patient at the ‘stand-alone’ FP service, also regarded the facility as a place for ‘kids’, as a result of the fact that the

²³ ‘Healthy Respect’ is funded by the Scottish Government and hosted by NHS Lothian as an approach to ‘create an environment that would lead to long term improvements in the sexual health and wellbeing of young people in specific areas of the Lothians’. It is delivered through ‘a network of local, easy to access young person friendly services...developed to increase young people’s access to services’ (Bigrigg and Glasier 2010: 61).

only time she had heard about the facility was through her daughter, who had attended talks at her school about it. Consequently, for some attendees such as Gem and Jules, identifying with the facility ahead of attending was difficult. Having never attended before, and with the impression that the facility was mainly aimed at young people, neither woman felt connected to the place. In fact, they expressed feeling somewhat out of place, or ‘other’ to the place. As a result, both women admitted they were more anxious attending than they would otherwise have been, with Gem saying:

‘What did I think? What did I think? Let me think...erm. Well just, I was probably more nervous about it than I would have been had it have just been at my GPs (*ok*)’.

When asked to interrogate this feeling of slight unease more, Gem moved on from talking about generational differences and began speaking about stigma, an issue that others also raised with regards to their emotions prior to attending:

‘Well... I hate myself for saying this but I probably feel that there’s still a wee bit of stigma attached to a sort of sexual health clinic, erm, and It didn’t bother me a great deal, but it was just there at the back of my mind...I did sort of wonder, erm, like, you know, would it be really busy? Would it be a bit sort of.... I don’t know.. Yeah, I just, I just didn’t know what sort of other people there would be there (*yeah*)’.

5.3.2 Secrecy and Stigma

Stigma, of course, is not a singular category of experience but is, instead, experienced in a number of ways. ‘Enacted’ stigma relates to individuals or groups *experiencing* discrimination on account of charges of being in some way deficient or immoral (*own emphasis* Scambler 2009: 450-451). ‘Felt’ stigma is the *anticipation* of ‘enacted’ stigma, when feelings of shame or blame imposed by dominant discourses are internalised (Scambler 2009: 451). Thus, the distinction is action, as ‘felt’ stigma relates to a fear of hostile action whereas ‘enacted’ stigma is the realisation of said action. Finally, ‘project’ stigma involves the ‘conscious rejection of attributions of shame and blame respectively’, signifying a resistance to the normative discourse (Scambler 2009: 450). Attendees’ accounts of anticipatory emotions linked to attending the facility relate to both ‘felt’ and ‘project’ stigma, with ‘enacted’ stigma in the anticipatory period left unmentioned, perhaps the result of the practice of secrecy or selective disclosure among attendees.

In terms of their workplaces, of course, there is no need to give details of a medical appointment. That said, attendees spoke, sometimes at length, about how and why it was so important that their work did not find out about their proposed visit to the facility.

Interestingly, this concern was expressed by both women attending the IUC clinic and those attending the ‘walk-in’, who may represent a more stigmatised section of integrated care, as ‘the meaning people make of viral STIs readily links with beliefs about individuals’ (Cook 2014: 12) morality.

Heli was attending the ‘walk-in’ in order to get tested having experienced vaginal itching for some weeks. Speaking in response to the question of stigma associated with attending the clinic, Heli said the following:

‘It’s a very good thing, – unless you don’t have sex, which is fair enough – it would be a very good thing to visit there and check yourself up no matter how safe you think you are’.

Heli’s comment above provides a good example of ‘project’ stigma, whereby she actively rejects the normative discourse of stigma associated with sexual health services, and those requiring them as being in some ways deviant, and instead re-appropriates being tested as ‘doing the right thing’ (Lupton et al 1995). Indeed, Heli did not think that she had an STI. She believed that she had thrush. Yet, and having tried over-the-counter treatments to no avail, Heli attended the facility and was tested for infections. Thus, Heli was enacting her belief that one should get tested, ‘no matter how safe you think you are’. However, when it comes to her work, Heli had a different outlook. Her confidence in the responsibility involved in attending the facility dissipated and, instead, Heli worried about how it would look to those who employed her in youth work:

‘Maybe it’s a bit, it seems just a bit, possibly irresponsible to need to go there potentially, like they might make guesses that you’re irresponsible or like, or like I’m going for a promotion just now so doesn’t it seem just a bit *young* to need to go there or something? Or unsettled? I don’t know (laughing)’.

When it comes to work, then, Heli felt that her attending could tarnish her reputation - challenging her confidence in her own narrative around responsible action. Heli was in her mid-twenties and clearly distinguished herself from the young people she worked with. As a result, Heli did not tell her work that she was attending the ‘walk-in’ and, consequently, she

had to take a sick day as she did not know how long it would take to make it through the clinic.

Heli was not alone in not wanting to disclose her visit to work. Ivy, who mentioned that the facility did not have the stigma that sexual health services did in the past, only told her partner and one female friend that she was attending the facility. She then went on to talk about how she had thought about what she should tell work:

‘I must admit I didn’t put it under the sexual-health clinic; I nearly did, because I’m very transparent, if I’ve got a hair appointment and if I’m doing it work time – you know, when you just kind of book a four o’clock – but they get loads of hours out of me so I tend to be quite transparent, and I’d rather be there at the front. But when I made the appointment and I was typing it in, I thought, yeah, do you know, I’m just going to get ribbed for that; and I thought, I don’t want them having mental images, so I actually just put it at 3:40 and I just put it as “clinic” because my directors look at my diary, and they’re boys, so I just put it...and it is “clinic” isn’t it.

Ivy’s narrative is fascinating on a number of levels. Firstly, she demonstrates how, despite being an open, ‘transparent’ person she did however struggle to decide on what to put in her work diary. There was a tension between her transparent self and not wanting her superiors to have ‘mental images’ of her undergoing the procedure. In addition, she speaks of the fact that her directors are ‘boys’ – something that she then qualifies by saying ‘I think if my direct superior was female I really wouldn’t have had an issue’. That the gender of her boss played a part in her decision to disclose or otherwise is interesting. So too is the fact that her male boss’ age was a cause for reflection. Being some ‘ten years’ her senior, Ivy felt that upon seeing ‘sexual health’ in the work diary her boss would ‘automatically think...wouldn’t they, you know, the stigma that there used to be attached to it years ago.’

Lucille also chose carefully whom she told about her trip to the clinic. She did not tell anyone that she was attending for her IUC, other than her husband. When I asked her whether she had consciously not told people, or it just had not come up, this was Lucille’s response:

‘It’s funny you should say that because, um, there is a woman at my office that I really like and we get along really well and I *wanted* to tell her (*uh-huh*). I wanted to say that I’d just gone and had a big lunch because... but then I thought ‘maybe that’s overstepping the mark’ (*aww*) but I did want to kind of seek a bit of, um, sisterly support from her (*yeah*) but I stopped myself ‘cause I thought I don’t know her that well and I don’t know, maybe that’s going too far’.

As well as concerns over work finding out about attending and the risks to reputation attendees feared, some also spoke of their desire to keep their attendance from their friends and social networks. Libby, who we met earlier, offers an interesting example of ‘felt’ stigma. Despite choosing to attend the clinic over her local surgery, she did so in secrecy, only telling her boyfriend of her plans. She did not tell anyone else:

‘Why? Just ‘cause it’s kind of like a bit of an embarrassing subject (*uh-huh*) and that kind of place is usually associated with bad things – STIs and all that (*ok*). Everyone kind of mocks that kind of thing (*uh-huh*). You don’t really want to go around telling everyone you’ve been there (*yeah*)’.

Libby is aware that, in her social world, ‘everyone kind of mocks’ those who have to attend a place like the clinic, where ‘bad things’ such as STIs are dealt with. Concerned not to be known for needing to attend and, thus, not speaking to any of her friends about her plans to go, Libby’s actions highlight how she had internalised feelings of shame associated with needing to go to a ‘sexual health clinic’, as she called it. For Libby, then, we see that she was very sensitive to the possibility that her identity might become ‘spoiled’, using Goffman’s (1963) language, should those in her social network find out about her time at the clinic.

Penny, a medic who believed she had caught genital herpes simplex virus (HSV) from her ex-boyfriend, was also concerned that people in her social network did not find out about her attending the clinic. However, what was interesting about Penny was how she contrasted her visit on account of suspected herpes – in terms of secrecy and stigma – to her previous visit when she got her LNG-IUS threads checked. In the former instance, Penny says she felt ‘responsible’ and not at all concerned with stigma. However, facing a visit based upon the fact that she had an STI, Penny felt completely differently, as the following excerpt from my field-notes suggests:

Penny says that there is still shame and stigma surrounding sexual infections. She says that it is interesting to compare how she felt when she came for the coil and how she feels now, coming for herpes treatment. Penny notes that when she came for the coil she felt confident, and responsible for taking the matter so seriously and bringing herself to the clinic. She doesn’t recall feeling any shame. However, today she feels that she is at the clinic because she has been ‘an idiot’. She feels embarrassed about the situation and doesn’t want anyone to know [18-02-2014].

Penny's account indicates a clear distinction in her experiences of the clinic on the day that I met her, when compared to a previous visit. Penny felt responsible when she attended for her IUC fitting and, conversely, on this occasion felt embarrassed. Her reasoning for this distinction was that, in her own mind, attending the facility for traditional family planning services warrants less stigma than attending for infection-related issues.

This section of the chapter has provided insights into the explanatory logics given by attendees for making the decision to attend the specialist facility. It has also allowed for consideration of the ways in which the clinic is experienced in anticipation. So far, this chapter has demonstrated that 'when an individual arrives at a given site, they bring with them a wide assortment of previous information that they use to imbue it with meaning' (Milligan 1998: 16). The following sections explore the variety of different ways attendees experienced the facility as they arrived.

5.4 Part Three: Being there

Before turning to the experiences of attendees as they traversed the frontier spaces of the facility, I will offer a descriptive introduction to the material landscape that makes up what I refer to as the architecture of transition. The description is born out of field-notes taken during my time conducting fieldwork, when I would travel through this landscape at various times of day. Without question, and in keeping with the interpretive nature of speaking about experience, this description is simply my interpretation, rather than representative of any distinct truth, this linking back to my aforementioned epistemological position, outlined in Chapter 3. 'Being-in-space', says Bollnow, using Heidegger's terminology, 'means something different from what we mean when we say of an object that is in a container. The difference lies in the fact that man (*sic*) is not a thing among other things, *but a subject that reacts to space*' (*own emphasis* Bollnow 2011: 254). As such, my description of the frontier spaces of the facility is my own. It is provided in order that the reader may have some context with which to understand the participant experiences that I will go on to discuss. Indeed, descriptions of place will be provided for this very reason throughout the findings chapters of this thesis.

5.4.1 Architectures of transition: A tour of the liminal spaces of the facility



(Architecture and Design Scotland, n.d).

The ‘frontier’ spaces of the facility are comprised of the outer boarded walkway and adjacent entry sign, the boundary wall, the raised walkway, the double set of heavy automatic glass doors and, finally, the foyer. All attendees, irrespective of their presenting need and care pathway, must travel this landscape both on arrival and, again, as they depart the facility. The journey, then, is a circular one – however, the journey is also one of change, as later parts of the thesis will demonstrate and, thus, in between entering and exiting through the same threshold, attendees undergo transformation. The frontier has a journeying, liminal quality.

As you move along this path, you become less and less visible to the outside, as the boundary wall narrows the field of vision for anyone outside on the adjacent street, or in cars waiting at the red light. Beyond the boundary wall is the raised walkway, measuring only a few feet. This section is met at its end by the first of two sets of heavy automatic glass doors, controlled by a button set at waist height (presumably for the benefit of wheelchair users) on the right hand side of the walkway. As soon as these doors open, you find yourself inside a small dividing space, what can be understood as a liminal space (Van Gennep 1960), with only a further set of glass doors ahead. This space – not yet inside but also no longer *exposed* - opens up into the foyer. The foyer itself has few features other than a leaflet stand, a wall mounted dispenser for laminated triage numbers, and objects to encourage appropriate self-governance, namely, a large CCTV wall-mounted monitor, and a notice stating the institution’s ‘zero tolerance’ approach to rude and inappropriate behaviour. These items ‘hint

at expected conduct' (White et al 2012: 4) within the space. Most notably, not only is the foyer unfurnished, without seating, its walls are also interspersed with three sets of doors (the aforementioned glass doors to the outside, plus two sets of inner doors: a sliding wooden door into the main reception, and a door for egress back into the foyer once an attendee has completed their clinic journey). As a consequence of the featureless landscape and the presence of doors, and the lack of seating, the foyer's architectural design symbolises its purpose as a space for movement, transition, temporality and liminality. Indeed, it is a space for those who are 'not yet arrived' (Mattingly 2010: 8).

Of course, my description of the frontier spaces of the facility, unpopulated and neatly segmented, is not representative of the way in which attendees experienced it. Therefore, the following sections provide some insights into how arrival into the frontier was lived, and experienced, by those making the journey for their own specific reasons.

5.4.2 Initial impressions – meeting the material landscape

The architecture at the frontier was noticed by Ivy as pleasant, or 'aesthetically pleasing' as she put it. Having never been to the facility before, and knowing very little about it, the initial impression of the material landscape was a welcome comparison to what she had expected – 'it's not all kind of old NHS', in a similar response to Joe's, mentioned earlier. Indeed, Ivy felt that the exterior of the facility was close to what she would expect at a private facility:

'I think when you walk up you've got the boards and things, and the doors, I think it's really nice. And it's almost, to a certain degree, almost like a private clinic'.

Ivy's positive response to the materiality of the facility remained throughout her clinic journey and will be returned to in following chapters. Her positive interaction with, and interpretation of, the material landscape was not unique, with other attendees, such as Samuel, also speaking of a 'certain something' evoked through the architecture of the frontier, and beyond.

Not all attendees, however, had such a positive response to the approach landscape. For Jules there were a number of issues that did not help to provide her with a welcoming arrival into the frontier. Embodied knowledge of pain associated with the fitting of a Cu-IUD or LNG-IUS device was something that Jules also found anxiety-provoking ahead of attending the

clinic. However, her main concern was her lack of knowledge of the place. For her, the facility was unknown and foreign, as the following excerpt from my field-notes suggests:

Jules spoke at length about how she didn't know what to expect when she walked through the door, or who would be her first port of call. This lack of information was something she found difficult and worrisome in the period prior to attending [22-10-2014].

For Jules, then, it was the lack of knowing about what to expect in terms of the material landscape and social interaction that exacerbated her already anxious mind, caused by prior bad experiences of being fitted with an IUS at the old 'stand-alone' service. Aware that she would struggle to attend due to her anxiety, Jules had a plan in place to prepare herself for attending, which included walking around the park prior to her appointment, talking to friends, and breathing techniques used to calm her down. Upon arrival at the facility, Jules noted that she felt the signage was 'corporate, cold' – something that she, as a former patient of the old 'stand-alone' SRH facility that had been located in an old Georgian town house, was not used to. Further, Jules experienced the walkway as a 'walkway of shame', because she felt exposed (thus, unlike me, she did not feel that the boundary wall protected her from outside gazes). This feeling was then exacerbated when the first set of glass doors did not open automatically, resulting in Jules standing on the walkway for moments during which time she felt 'under scrutiny' from the outside. Already suffering from anxiety around her procedure and worries about what to expect, this experience at the frontier did not help. Jules was not alone in this experience of being observable, indeed, others, such as Lucille, felt that there was a lack of 'discretion' to the entry way. Attending for the IUC clinic, Lucille felt that the privacy of the procedure demanded a better concealed entry:

'I suppose you just.. it's just, it's just quite private and there it is every time you walk in that entrance people know...even, even if they put 'family planning' on that big a sign I'd probably feel self-conscious (oh ok). It's just that it's, it's um, yeah, it's kind of advertising why you're going in there and it just seems a bit like it's on such a busy street'.

Returning to Jules, it was only when she had 'passed the threshold' of the glass door that she felt more comfortable.

5.4.3 The foyer – materiality

The foyer, referred to by attendees in a number of ways including ‘the holding pen’, ‘the non-waiting, waiting room’, and ‘that wee place’ once entered, was a space that many of the attendees found unusual, or unexpected. Most notable to attendees was the lack of any seating. While I have suggested that this was an intention of design, attendees to the ‘walk-in’ did not often see it this way, with only Joe commenting that, ‘if I was just passing through there it’d be nice, you know, given that it’s not really a waiting area anyway’. Of course, Joe’s comment is important, as it speaks of the difference in experience of those who might have to wait in the foyer against those, mainly booked appointment holders, who could just walk straight through it. However, for the most part, attendees who had to spend time in the foyer waiting for the service to open found it unusual, uncomfortable, and even unprofessional not to have seating available, as the following comments from Penny and Harish suggest:

Penny says that she is glad that the area is open for people to go into, rather than standing out in the street looking like ‘tramps’. Penny then, however, says that it is a bit odd that people must sit on the floor because this would be unacceptable in any other health facility [18-02-2014].

Penny’s comment is interesting, because it points to her aforementioned ‘felt’ stigma around being known to attend the facility – she doesn’t want to be out in the street waiting, looking like ‘tramps’. However, while the foyer provides some privacy, its lack of seating is something that Penny finds an oddity, and certainly not something that would be acceptable in other health facilities. As a medic, Penny notes that this is something that is rather unusual for a space that is used as a waiting area. Harish, also commenting on the lack of seating in the ‘non-waiting, waiting room’, emphasised the fact that being in the space was uncomfortable, rather than unacceptable:

‘The initial, sort of non-waiting, waiting area..Um, it’s not, it’s not very comfortable space to wait at...so I wasn’t, um, I was ok with it but I wouldn’t say I was 100% comfortable with it because first there is no proper place to sit, plus there are about 30 people in that space, um, just trying to find space to squeeze in’.

Harish’s comment makes the important point that attendees did not spend time in the foyer alone. Rather, they share the space and, as such, the small space was experienced not only in

terms of its design characteristics – it's small dimensions and lack of seating – but also in relation to the social landscape found within which, depending on the day, could be momentarily home to some 30 people, of differing ages, gender, sexuality, etc., who could be attending for interventions, testing, diagnosis and/or treatment. This raises what Noble (2008:18) refers to, in her study of travel on Lothian buses, as 'the implications of bringing people from different social spheres together and confining them in a small and limited space'.

5.4.4 The foyer – where the material and social landscapes meet

Experiencing the space as intimidating, or just uncomfortable in some way, was a common refrain for those who spent any time in the communal space of the foyer. Libby's description offers an insight into why the space had this atmosphere:

'It was kin...probably like intimidating, like everyone was just, it was just silent... no-one was really speaking. No-one made eye contact or anything'.

For Libby, who was anxious about attending a facility she associated with embarrassment and secrecy, the *quietness* of the foyer was what was intimidating. Upon entering the foyer from the outside, she immediately read, or sensed, the atmosphere of the setting (Edvardsson, Rasmussen and Riessman 2003: 377). Not knowing what to do, Libby mimicked what she saw the others doing:

'I just like walked in and there was like ten people just like all up against the wall sitting on the floor (uh-huh). And I walked in behind a guy and he got a ticket so I was like 'ok, I take it I have to have one of these' so I got a ticket (uh-huh) and then took a seat on the floor with everyone else [laughing]'.

In Libby's account, she speaks of what Hirscheuer (2005: 52), in an ethnographic study of elevator rides, calls the 'social constitution of an asocial space'. Goffman (1963: 84) describes what he calls "civil inattention", whereby "one gives to another enough visual notice to demonstrate that one appreciates that the other is present (and that one admits openly to having seen him) while at the next moment withdrawing one's attention from him so as to express that he does not constitute a target of special curiosity or design'. Hirscheuer applies this concept to the ethnographic study of an elevator ride, to characterise how people act in tune with one another to create a space that is devoid of interaction. It is this 'civil inattention'

that resulted in Libby experiencing the foyer as ‘intimidating’ and ‘awkward’. With no-one talking, and people avoiding eye contact, Libby simply sat down, and used her phone as a ‘prop’ until the main reception became accessible. Libby’s commentary on how she behaved in the social space of the foyer is something that others spoke of – a type of *practicing of*, or *way of being in*, the foyer. Holly provides another example, saying:

‘I noticed in the foyer bit that they had that stand, ‘cause I sat quite close to that (umm) but I didn’t really look around and mu...many of the posters (uh-huh) ‘cause, like, it’s kind of awkward ‘cause there’s people around you and it wasn’t necessarily that I don’t want to make contact, eye contact with them but they seemed a bit like, ‘I don’t want to look at you’ [laughing] so I was just like, ‘ok, I won’t look at you – I’ll just keep looking at my notes’. Yeah, I think everyone’s just a bit like, ‘urgh’

Here Holly is referring to the information stand that is kept in the foyer, holding leaflets about a range of issues pertinent to the service. Holly indicates that she did not look at these leaflets, or posters, on account of it being awkward ‘cause there’s people around’. She then goes on to suggest that she picked up on the social cues dictating that one should not look at others within the space and, instead referred to her university notes that she had brought with her. Penny had a very similar account, as the following notes from our unrecorded interview demonstrate:

Penny says that she had been looking at a leaflet about transgender women in the foyer, as she didn’t know anything about the issue and thought that she may as well read it. However, when she noticed that she recognised someone in the foyer she says that she put it down, as she didn’t want him to think that she was a transgender woman (she laughs at this a little) [18-02-2014].

Penny’s example indicates a similar concern to that voiced by Holly, that in reading the information on display, others around you might deviate from the accepted practice of civil inattention and, instead, observe you and judge you, based upon the reading material you have selected. The difference between the two examples is that Penny recognised someone she knew. What these accounts, when taken together, suggest is that being in the frontier involved complex social interaction and reading of the landscape. Civil inattention comes into play, as attendees acknowledge one another on a cursory level and then take pains not to engage further, so as to try and engineer a more comfortable environment (although the result, as we have seen, is that this can be counterproductive). In terms of the atmosphere of the

frontier, and the foyer specifically, we can see that there is a ‘propensity’ to it (Bissell 2007: 272). In other words, there is an affect that governs action among those within the place, and generates emotions or feeling - a disciplinary capacity of the atmosphere within the frontier (Bissell 2007:272-273).

Another participant who found the ‘social landscape’ (Gesler 1992) of the foyer uncomfortable to be in was Stuart. Despite having come to the facility on multiple occasions (and thus knowing what it involved in terms of the social landscape) Stuart said he still found the atmosphere uneasy:

‘Aye, in that wee place [gesticulating towards the foyer] thinking oh these people can, you know, they can see you and they’re like, ‘oh, I know why you’re here, I know why you’re here’, umm, and that’s a wee bit embarrassing’.

For Stuart, the source of his embarrassment is that he feels everyone knows why he is there, and that there is nowhere to hide, so to speak, this concern echoing those of some of the gay men included in the study of the acceptability of integrated service provision by Griffiths et al (2008: 4-5). Indeed, using Hirschauer’s (2005: 52) ethnographic study of elevator journeys, ‘everybody entering the uneventful space...is an eye-catcher for all inmates...but while looking around for a place, entering persons can also try to catch a fleeting glimpse of the fellow passengers’. Arguably, it is this seeing and being seen that works to make Stuart self-conscious in the social landscape of the foyer.

One way of not having to navigate the intimidating or simply uncomfortable foyer was to avoid being there. Danny, with previous experience of the facility and knowledge of the triage system, described his strategy for avoiding the foyer during ‘walk-in’, saying:

‘Because the doors open at half 8 and there’s about 40 tickets if you come at half 8 there’s already going to be people here, so you’ll only have ticket number 28, 30. Today I got 6, last time I got 3 – gutted [laughing] um, but I found that..we’re quite central so I can just go for a cup of tea and come back for half 8, save just waiting around in the, well, the vestibules (umm) – there’s not really a waiting area, so um... yeah, that’s my strategy’.

For Danny, who found the social landscape of the facility challenging, as a gay man who experienced ‘stigma on a daily basis’, knowledge about how to ‘play’ the triage system allowed him to miss out on the stressful experience of being among others in the foyer,

waiting. Indeed, Danny's expertise and understanding of how 'walk-in' worked was something that he spoke of proudly, on account of the fact that friends would ask for him to accompany them:

'One of my friends asked me to come with her because I knew the system. And I had another friend once who didn't live in the centre and I knew she wouldn't be able to get here in time so I came early for us and got us both tickets so that when she arrived she'd get seen promptly. So I bucked the system'.

This section has shown how the confinement of attendees in a small socio-material landscape can exacerbate the anticipatory anxieties that some attendees experience. This can inhibit attendees' ability to freely occupy themselves by reading available materials or otherwise behaving as they wish. But not all attendees had such negative experiences of the foyer.

5.4.5 Solidarity

While the aforementioned experiences speak of an intimidating, embarrassing, or simply uncomfortable, unrelatable foyer, for others the experience was not so daunting. Rather, the presence of other people was felt as a reminder that one was not alone in their experience. As Heli put it:

'It's like this feeling of solidarity in there I think, you know, everyone's there and everyone's like quiet but I felt some solidarity'.

Solidarity, or 'being with', as part of 'a mobile collective' (Bissel 2010: 270) has a powerful resonance for attendees such as Heli and Joe, the latter noting that there is comfort to be found among the throngs:

'The mass of people that are there makes you feel like you're not the only person that has put themselves in a risky situation so you don't feel as uncomfortable'.

Trusting that 'everyone's here for the same reason', Jimmy also felt ok while waiting in the foyer. The sheer numbers that arrived at the 'walk-in' on a given morning was something that worked to 'make coming feel normal' and so, for Jimmy, as well as Heli and Joe, it was not intimidating to be surrounded by others but comforting. They regarded those around them as similar to them, as opposed to Ivy and Maddie, who saw themselves as different, apart and

thus, found the experience of the foyer or the frontier spaces less comforting and more challenging to their sense of belonging.

In terms of solidarity, this extended to action in terms of individuals waiting in the foyer guiding others to the triage numbers, or imparting their knowledge of the system to those who did not know what to do upon arrival into the space. Holly, who had not been to the facility before, gave an example of how others around her – those who had arrived before her – helped her to navigate the landscape and figure out the system, and then how she also adopted this role of expert for other new arrivals:

‘I, like, when I first came in, there was one guy sat on the floor so I said, ‘oh, do you just take one of these’ and he was like ‘yeah’ and that was it. And then a few people came in late and asked me where I got the numbers from and I was like ‘oh they’ve all gone’.

So, the foyer was experienced as intimidating by some, and more of a place of solidarity by others. Perhaps these experiences of the foyer were linked to aforementioned reasons for attending. For example, Libby mentioned feeling ‘intimidated’ by the social landscape of the foyer and this experience might well have been exacerbated by her lack of previous experience of the facility. Indeed, Libby referred to places throughout the facility as ‘intimidating’, often linking this to her lack of understanding of what was going on. Conversely, Heli spoke of the sense of solidarity she felt within the foyer and, again, this interpretation of the social space might well have been the result of her own sense of doing the right thing by attending.

5.5 Conclusion

This chapter covered the early stages of attendees’ engagement with the facility, discussing reasons for attending which, as we have seen, were linked to notions of risk and responsibility, to self and others. In addition, we saw that attendees’ accounts of their initial experiences of the facility aligned with the sociological understanding of place as ‘doubly constructed’, whereby the material environment is further interpreted as a result of the meanings and values people attach to it (Gieryn 2000: 465). Through a process that Davidson and Milligan refer to as the ‘emotio-spatial hermeneutic’ (2004: 524), we see how attendees experienced emotions in response to this particular space – the foyer – and that, in

experiencing such emotions, they reconstructed it for themselves, as a space of solidarity, intimidation or boredom. The next chapter, 'Admission', continues on the clinic journey, as attendees move from the periphery of the facility into the main waiting room – the central 'sorting space' wherein the heterogeneous crowd undergoes institutionally mediated categorisation.

6. Admission

6.1 Introduction

This chapter focuses on attendees' onward passage through what I refer to as the 'sorting spaces' of the facility, namely, the main waiting room and triage, the atrium and smaller 'hub' waiting areas. I focus on the influence of the distinct affective characteristics of each of the 'sorting spaces', alongside considerations of the influence of these spaces' temporal location on the journey of admission in order to understand participant experiences. Specifically, I focus on experiences that emerged as a result of being asked to wait, among others, in the various 'sorting spaces'. In addition, I examine experiences of the social processes of admission, from the attendees' and staff members' points of view. For each of the stages discussed, description of the space is provided in order to offer contextual detail that will foreground the participants' comments.

6.2 Stage 1: The main waiting room and triage



Nicholson, n.d



Author's own



Author's own

As was discussed in the previous chapter, attendees came to the facility with certain preconceptions and expectations. For some these were the result of having been to the facility before. For others these were the result of coming to a new facility, or a new type of facility altogether, and the assumptions they brought with them. I now turn to discuss how attendees experienced their time in the main waiting room – the first of the ‘sorting spaces’ that they waited in, and passed through, on their admission into the clinic. I begin with a description of the space – its form and function – before representing attendee experiences across the following themes: physical landscape; social landscape; and the social function of admission.

6.2.1 A thick description of the main waiting room

Crossing the interior threshold from the foyer, one enters the main waiting room. As the photographs above capture, this first ‘sorting space’ is painted in a light, bright, inoffensive tone while also incorporating moments of colour in cool, calm green and blue. The lighting takes on a playful character, with bauble lanterns hanging at varying lengths down into the room. It is spacious, not least when compared to the foyer which, as we know from attendees’ comments in ‘Beginnings’, could be experienced as somewhat cramped. The two triage rooms occupy the far end of the room, identifiable by their green doors. The main waiting room is light and airy, with the exterior wall of the room punctuated along its span with large sash windows which – and on particularly sunny days – contribute to the ambience of the space. Further features of the space indicate consideration for those who will occupy the waiting room, for example, the provision of a smaller zone, sectioned off from the larger space by a partial wall (depicted in the second photograph). This seating area was incorporated into the design so as to offer ‘maximum confidentiality’ to those who might wish it, out of view from the larger crowd (Standard Business Case 2007:12). Familiar objects feature, such as magazines placed inside wall mounts, public health posters displayed on notice boards, and a small selection of toys for children to play with as they wait with their parents or guardian. These smaller objects offer an additional ‘textual layer’ to the space, as Evans and Crooks (2009: 166) refer to them in their study of medical aesthetics. There is, however, a noticeable absence to the space, that being the lack of art or photographic images on the walls.

In terms of its organisational function, the main waiting room acts as the threshold between the public and private spaces of the facility, wherein attendees and gatekeepers interact – a

point to be discussed in more detail below. Triage nurses and reception staff engage in the activity of creating ‘kinds of people’ (based, for example on a care pathway) from the heterogeneous, undifferentiated masses (Hacking 2007: 150). Through interacting with attendees, staff categorise individuals under organisational labels (NTT, general clinic or booked appointment), thus determining the care pathway each attendee will follow, and the further ‘sorting spaces’ they will occupy. For others, access is denied. Pütz (2012:165) says of the airport security checkpoint that:

‘Architectural design guides travellers...Design designates certain areas for others for immobility and waiting...to physically access airside, travellers have to pass the checkpoint; other ways are physically blocked. Doors secured with alarms and glass and brick walls divide the more accessible landside where check-in is located from the more secure airside where the gates are located. The security checkpoint is the bottleneck that connects landside and airside’.

While I do not propose that the clinic is an airport, this description is remarkably applicable to the main waiting room and, as the following accounts and discussion thereof will demonstrate, movement beyond the main waiting room is highly ordered and monitored, contingent upon attendees adhering to the rules of the social space. To pass through from the main public waiting room (‘landside’, in the airport comparison), to the private, clinical spaces beyond (‘airside’), attendees must pass through their own checkpoint, managed by triage staff and reception team members.

6.2.2 First impressions

A period of waiting within the main waiting room, prior to interacting with gatekeepers, is almost inevitable for all attendees, albeit variable in terms of length of time. Booked appointment holders would perhaps only pause momentarily in line before being called to register their presence, while ‘walk-in’ attendees might sit for more than an hour before being called in for triage. The point to be made, then, is that for all attendees, the first impression of the main waiting room was not of an interaction with staff members but, instead, was with the space itself and those others waiting therein.

Attendees appeared pleasantly surprised by the appearance of the space, describing it with complementary adjectives such as ‘bright’, ‘light’, and ‘open’. Roisin, who had spent time in the foyer, said:

‘I really liked the green décor of the nurses’ things, um, rooms. You know, it’s a nice, big space, there’s a nice atmosphere to it. I don’t know, I guess you know it’s a grotty test – you get to sit in a grotty place’.

For Roisin, the main waiting room was contrary to what she had expected. Having never been to a sexual health clinic before her only ‘experience’ of such a facility was what she had seen on ‘a reality TV show’ about a sexual health clinic in England, in which the facility ‘came across a bit grim’. The fact that she had also spent some 45 minutes sitting on the floor in the foyer had done little to change her expectation and, yet, upon entering the main waiting room, she was pleasantly surprised, as the continuation of her quote from above indicates:

I don’t know, I guess you know it’s a grotty test – you get to sit in a grotty place’. But it wasn’t, you know, it was spacious and, you know, plenty of chairs, so yeah, it’s nice’.

It was not only those who spent time in the foyer who found the aesthetic of the main waiting room unexpectedly pleasing. Pippa, who was attending the facility via the booked appointment pathway also used the adjective ‘grotty’ when talking about her expectations of the facility. Unlike Roisin, Pippa had been to many different sexual and reproductive health care facilities in her lifetime, including the now closed ‘stand-alone’ FP service, where she had attended for some fifteen years. In fact, it was Pippa’s memory of the waiting room at the FP clinic that caused her to expect the new facility to be ‘grotty’ as well:

‘It’s a lot more... clean and clinical in its appearance but that’s not a bad thing. You know, [there] you’d be sitting in the waiting room. The waiting rooms were grotty whereas in there it’s clean, it’s fresh, it looks bright. Erm, um, you’d climb up the manky carpets that god knows what’s been spilt on it, d’you know what I mean?’

For Roisin and Pippa, then, the appearance of the main waiting room at the facility –its proportions, use of colour, cleanliness and fresh paint – made a positive first impression of the facility that was unanticipated. Neither were particularly anxious about their visit, and yet the space was experienced as pleasant. Thinking more specifically, however, about the potential for the physical landscape to be *therapeutic*, rather than simply aesthetically pleasing, Jules’ account of how the main waiting room’s aesthetic helped to calm her nerves is insightful. Recounting how she had arrived at the facility ‘in quite a state’, due to her anxious anticipation around the pain involved in the process of getting her LNG-IUS fitted, Jules

noted explicitly that she liked the colours in the main waiting room, as well as the light, for it ‘helped me keep my mind off what was about to happen’. Jules, who was introduced in the previous chapter as particularly anxious, and who did not like the physical landscape of the frontier spaces of the facility, found comfort in the main waiting room, and the spaces beyond, due not least to their affective aesthetic. The case of Jules demonstrates how the physical landscape of a space can have an effect on mood and emotion – both negatively, as was her response to the exterior of the facility discussed in the previous chapter, and more positively as is the case here. What Roisin, Pippa and Jules suggest in their recollections of the main waiting room is that the intention of the space – that is, the ideals of providing a ‘relaxing, calming, open and accessible’ facility, as one stakeholder communicated to me – had been largely successful. Despite their positive comments, however, another attendee picked up on the lack of art in the waiting room, saying:

‘You know, it would just be nice to have some nice pretty paintings of trees or something – it’s what you want to see. Not some tatty, old magazines on a rack’.

Harriet’s comment about a space wherein, she suggested, ‘people are probably really anxious’ does raise the question of why, given the aforementioned intention to make the spaces of the facility calming and relaxing, art is not on display in the main waiting room. The presence of art in spaces of healthcare, including waiting rooms, is an increasingly popular practice, evidenced in government and third sector endeavours, influenced by academic contributions²⁴. Commenting on the rationale behind the placement of art at the facility, a staff member indicated that there was never a ‘clear strategic plan’, however, the main waiting room was thought to be ‘cluttered’ in appearance and, subsequently, putting art on the walls was not considered. Instead, it was in the vast, empty atrium that art was installed, in an attempt to introduce colour and ‘thought-provoking’ (rather than ‘Scottish landscape’) pieces to the grand space²⁵. Returning to Harriet’s comment above, when considered alongside that of the staff member, it is possible to identify some discordance, in the first instance relating to the placement of art throughout the ‘sorting spaces’ and then, secondly, with regards the style of the art itself. While Harriet indicates that she would like to see pictures of therapeutic

²⁴ Kings Fund, charities like Art in Healthcare (Edinburgh), as well as research from environmental psychology, medical geography and others.

²⁵ Over the years since opening, the facility has seen photographic exhibitions on LGBT relationships, mixed marriages and sculpture installed in the atrium.

places on the walls, this type of perhaps innocuous art is overlooked by those making the decisions, offering a clear example of top-down, intended ‘aestheticization’ whereby ‘the construction of place as aesthetic-therapeutic’ is a reflection of managerial decision-making (Collins 2007: 351). This said, it seems that for most of the attendees, the aesthetics of the waiting area was better than expected, irrespective of the lack of artwork adorning the walls. This, perhaps, reflected their preconceptions of such facilities as being ‘dingy’. With the stigma associated with GUM services resulting in the speciality’s position as a ‘Cinderella service’ within the NHS (Bigrigg and Glasier 2010) this preconception is not unfounded. In the move from ‘stand-alone’ services to the integrated clinic, however, we see what Prior (1988: 87), in her study of ‘spatial organisation and medical knowledge’, reflects as being a change in design that comes with a ‘revisions of nomenclature’. Thus, the ‘integrated’ clinic – in the case of my field-site – is designed as modern, clean, welcoming, and this compared, by participants themselves, with the dark, dingy clinics of the past.

So far I have considered attendees’ first impressions of the main waiting room and discussed the examples of those for whom the physical landscape was noteworthy. For many their first impressions were positive, a relief from the cramped conditions of the foyer or their preconceptions of a sexual health facility. I now focus on the social landscape of this ‘sorting space’. Like the foyer before it, the main waiting room is socially heterogeneous, the result of the social function of the space to differentiate, categorise and spatially arrange attendees through interaction with gatekeepers. The following considers how attendees experienced this space and time along the journey of admission.

6.2.3 Experience of social landscape: Distinction

‘On entering a room one can feel oneself enveloped by a friendly atmosphere or caught up in a tense atmosphere. We can say of a persona that s/he radiates an atmosphere’ (Bohme 1993: 113).

Despite the intention for the facility to be open and accessible, some attendees found it noteworthy that the heterogeneous population of the main waiting room raised questions of identity and belonging, or triggered a sense of judgement. Indeed, as the above quote indicates, the atmosphere of the main waiting room – as with the foyer before it – could be

experienced by individuals very differently. How individual attendees interpreted and perceived those around them influenced their experiences waiting in this communal space.

For reasons that appear to be hinged upon concerns over being ‘misclassified’ as requiring infection-related services (rather than family planning), Harriet found the integrated population of the main waiting room objectionable, saying:

‘I don't want to be with the people for drop-in. I don't know why it matters, but I want that sense of community’.

Harriet, who also found the heterogeneity of the foyer difficult, speaks here of a sense of community that is lacking as she waits in the main waiting room. Instead, she shares the space with those that she constructs as ‘other’ – ‘people for drop-in’. Of course, those attending the ‘drop-in’, as Harriet referred to them, might well have been attending for reasons similar to herself but her perception was that there was a clear distinction between her and them. Perhaps her most explicit statement was that she worried about touching anything in the main waiting room – a space she regarded as contaminated by the ‘grubby fingers’ of those others attending. In this way, Harriet regarded the objects in the space, such as the magazines, even the chairs, as what Douglas calls ‘conductors of impurity’ (Douglas 1984: 34).

Harriet was not alone in expressing feelings of difference between herself and those around her, in the main waiting room. Maddie and Jennifer – both women whom, like Harriet, were seeking contraceptive services through booked appointments (Harriet and Jennifer) or via the ‘walk-in’ (Maddie) – also noticed that they were among people who they did not identify with, with Maddie saying:

‘The waiting room’s not the nicest thing you’re ever going to have to do in your life – you’ve got two teenage girls giggling who are obviously there for something they feel embarrassed about...it made me feel like I was there for something I should be or feel awkward about whether it was unplanned, um, emergency contraception or an HIV test – something that I might feel slightly dodgy about – it made me feel like that even though I’m there for, as a grown woman making a positive decision about her contraceptive choice I was put into a situation that felt quite uncomfortable (*mmm*).

What is particularly striking in Maddie’s comment is that she clearly distinguishes from others around her, in such a way that mirrors wider public discourse related to, on the one

hand, responsible contraceptive choices and, on the other, irresponsible need for testing services. As Foucault (2003: 252) suggested in his lecture series ‘Society must be defended’ (1975-76), sexuality is linked to, both, individual bodily control (including control of reproduction) and sexual debauchery and disease (2003: 252). While it may be argued that attending the facility for testing services might be reframed as a responsible act, it is nevertheless the case that in our public discourse SRH evokes ideals of voluntary regulation and control while those in need of testing services are regarded as a public danger. Unlike the others present in the room, Maddie was not there for ‘something that I might feel slightly dodgy about’ but, rather, saw herself as a responsible ‘grown woman’ who was doing the responsible thing. Again, as with Harriet, the distinction was clearly made, despite neither Harriet nor Maddie knowing for certain why others around them were in attendance, thus basing their assessments on stereotypical assumptions founded upon, perhaps, age, gender and behaviour (‘teenage girls’, ‘giggling’).

Jennifer also commented on the people with whom she shared the initial waiting space, saying:

‘There are all sorts of people in the waiting room – clearly gay men and HIV positive people. So I like the way that there’s different waiting rooms later – not that I want them segregating but I think everybody feels more comfortable if they’re in the waiting room for your designated thing, you know’.

While integration research has suggested that women attending for contraceptive only purposes have reported feeling more stigma when compared to attending a family planning service for the same reason (Sauer et al 2013), what these accounts point to is, rather, a sense of distinction.

These accounts of the social landscape of the waiting room make reference to the ‘affective quality’ (McCormack 2008: 1827-28) of the space which is influenced by the others found within. In this way, and as I now go on to discuss in more depth, the way in which the main waiting room influenced experience was ‘never only something personal...[instead] a product of a complex mix between...light, sound, bodies, gestures’ (McCormack 2008: 1827-28).

6.2.4 Mimicking the organisational function of the main waiting room: Categorising others

In their narratives of distinction, Harriet, Maddie and Jennifer provide a clear example of how, in the social space of the main waiting room, it was attendees who engaged in a practice of unofficial differentiation and categorisation of those around them as they waited – thus mimicking the organisational function of triage and reception. To this end, Harriet suggested that the ‘theatre-style’ configurations of the chairs in relation to the triage rooms and reception desks facilitated her practice of observing, listening and assessing. The ‘dramaturgical’ setting that Harriet described demonstrates how the social and physical landscapes overlap to influence the experience of those waiting in the space:

‘I mean, you’re sat there, theatre-style, and there’s nothing else to do but watch people get up, go to the reception. You can basically just *listen*’.

While this was surely not the intention of the design of the main waiting room, it is nevertheless the case that there was an awareness among staff of the potential for privacy to be compromised within this social space. Pointing to the difficulties experienced in modern times, when the designer and the user are separated (as opposed to a time in ‘traditional societies’ when objects were commonly made and then used by the same person) Heylighen and Strickfaden (2012: 82) note that ‘the direct feedback loop between material and immaterial is interrupted...How the user eventually experiences the designed environment may correspond to what the designer intended but might also differ from those intentions in varied ways’. In the context of the design of the facility, this experience of the main waiting room as a stage would likely not be the intended effect, yet it was experienced as such by anxious, and perhaps slightly embarrassed, attendees. In an effort to mitigate against the effect of the spatial arrangement, pop radio is played in the main waiting room, a strategic tool for the protection of privacy, as one staff member explained:

‘That’s why we have the radio on, because the cubicles are actually quite close to each other and you don’t want people listening into each other’s personal information, so we always put the radio on for that reason. That’s the strategy behind it, you’ve got music and it’s to sort of make people feel a wee bit more relaxed that people aren’t listening over their shoulders’.

While attendees such as Maddie, Harriet and Jennifer categorised themselves as different from those around them and did not, it seems, feel themselves to be the recipients of other people's judgement within the space, Danny felt that he was on the receiving end of potential scrutiny. Despite having attended on numerous occasions, Danny still felt that it was a space wherein he might be stigmatised by others around him, as this longer excerpt from our interview shows:

D: 'You do look around and wonder, oh they're probably thinking what have I got or, look - what's he in for?

S: 'So you feel a little bit like you might be..'

D: 'Might be judged (*uh-huh*). Like, uh, stereotyped like 'there's another gay man who is constantly getting infections', you know I've already got that stigmatism from being gay, like (*uh-huh*) so I get stigmatised like every single day, and stereotyped every single day so to come here, I'm expecting the same. Um, but to be fair the doctors and nurses and health advisers, they're not like that. I just feel like I'm going to get it from everybody else'.

S: 'So other people, maybe other visitors'?

D: 'Yeah they tend to intimidate me. Like even sitting in the waiting room everyone's just looking at each other and it's just kind of.. just *awkward* (*umm*). That bit I don't like'.

For Danny, then, the main waiting room was a space wherein he was self-conscious of the judgement of those around him. Danny's comment points to what Griffiths et al (2008: 4) found in their study of the acceptability of OSS facilities among potential attendees, including gay men, whereby they note that 'fear of potential homophobia' was raised as a reason for OSSs being viewed as undesirable. For Harriet, Maddie and Jennifer, conversely, the main waiting room was the social space within which they did the assessing – and judged – other people as different from themselves.

Waiting is socially experienced in the main waiting room. In other words, and as we have already discussed, individual attendees waited with others. As the following accounts indicate, it was this social waiting that caused them to adapt their behaviour. Maddie provides a clear example of this when she recalls:

‘After my first triage thing, and I had somebody sat either side of me and I didn’t really want to sit and look at those while (*oh..*) I had somebody sat there (*yes*) and I had to fill in a check-list and I had people right next to me, so that’s not really ideal if you’re asking people to read stuff (*mmm*) and I could’ve been looking at something far more sensitive than that (*uh-huh*) presumably, or could’ve felt more sen..could’ve been a more sensitive person [laughing] erm and, and not been comfortable (*mmm*) reading that stuff’.

Here Maddie was talking about how the triage nurse had provided her with two leaflets about the Cu-IUD and the LNG-IUS, given to her so that she could read up about the difference between the two devices and make a decision about which she might prefer to have fitted. With the main waiting room full, Maddie felt that there was not enough space for the privacy she desired in order to read through the documentation. Maddie’s feeling that she could not read her documents for fear of others seeing what she was reading about – thus exposing her reason for attending – is similar to Penny’s self-consciousness about picking up a leaflet about transgender issues whilst waiting in the foyer, mentioned in the previous chapter. In both instances, we see that the presence of those around them – the social landscape of which they are a part – has a disciplinary power, influencing their behaviour. As Bissell (2010: 272) notes, ‘where Foucault (1977) describes the disciplining effects of material spatial arrangements, *the immateriality of atmosphere might serve as an equally powerful disciplinary force*’ (*own emphasis*).

What attendees’ accounts of their time in the main waiting room attest to is that, while stuck together in ‘enforced intimacy’, as Bishop (2013: 138) suggests of the architectural influence of the waiting room, those in the space occupied themselves in a number of ways, including ‘sizing up’ others. Bissell (2007: 285) notes that, ‘in many ways, an active *doing* of waiting and how a subject comes to wait could be seen as an achievement of a specific set of ongoing embodied tasks. These might include the agentive capacity of making decisions about where to wait and what to *do while waiting*’. Harriet, Maddie, Jennifer and Danny all remind us, in their accounts of the main waiting room, that waiting is not only experienced alone, but it is ‘entirely performative, *social*’ (Bissell: 2007: 285). What to do while waiting, and how to act in the social space are considerations made by those ‘trapped in this space together’ (Tanner 2002: 118). What was missing, however, in participants’ accounts of the waiting room was any commentary about their assessment of staff members who shared the space with them. As Pryce (2000: 298) notes of the waiting room at the GUM clinic, while this space was

designed for staff to observe ‘clients’, these ‘clients’ also regarded staff members as objects of a ‘counter-gaze’. This, however, was not mentioned by my own participants who, instead, seemed preoccupied by their own concerns.

6.2.5 The social function of the main waiting room: Waiting, registering and being admitted.

Having considered attendee experiences of the physical and social landscape of the main waiting room, I now turn to the social function of the space and participant experiences thereof, starting with the requirement to wait.

Holly, who we met in the previous chapter as she arrived to the facility for NTT, reflected on how she felt in different spaces and at different times along the care pathway, specifically distinguishing between the foyer and the main waiting room, saying:

H: ‘When I first sort of came in and was waiting that was fine. When we went through into the other sort of waiting room where you wait to be called your number I was quite, like, nervous then (*umm*). I was getting a bit worked up (*umm*). And then yeah, I was just sat with you having a nice chat. That, you know, that probably made it a lot better – it was better than waiting on my own ‘cause then I’d probably work myself up again’.

S: ‘And why do you think you were feeling so ‘worked up’ as you say?’

H: ‘Just like, um, anticipation of what it was going to be like. Like not knowing what would happen’.

Holly’s comment about sitting with me and how that made it better for her to wait is something that will be returned to in a later chapter, for she was not the only participant to suggest that they might have opted-in to the research in order to have someone with them. For the time being, however, Holly’s comment speaks of her generalised concerns over ‘what it was going to be like’. She had not been to a sexual health clinic before, let alone this facility, and so was unsure about the process that awaited her. In her study of the lives of women working in the sex industry, who would often attend a GUM clinic in London, Day notes that ‘first time visitors find the experience difficult and are often embarrassed at the prospect of being seen or recognised, worried about possible infection and anxious about the prospect of genital examination’ (Day 2007: 15). While Holly did not specify the root of her

anxiety, Day's observation in her own work resonated with those of other attendees, for example Joe, Antonia and Garry.

Joe, who we know from the previous chapter was attending the facility for testing services, reflected on how he felt as he waited, saying:

'Er, well when you're on your own, you just kind of think – I think all you can think about is 'what if I have something' (*umm*), like that is all you really think about so you're kind of just anxious to get in, get done and get out'.

Here Joe points to a specific fear of being infected that might occupy his mind while waiting. Crucially, however, he suggests that this occurs 'when you're on your own', thus hinting at a change in the experience of waiting between the initial moments when he was on his own and the latter stages of waiting when he was accompanied by me, the researcher. Lastly, Joe's comment points to a desire for the process to happen quickly – like pulling off a plaster – 'get in, get done and get out'. A similar view was conveyed by Garry who was also left waiting anxiously, preoccupied by his fears of having contracted HIV:

'All I can think about is, 'what if I have it' (*umm*), like that is all I can really think about'.

For Holly, Joe, Antonia and Garry, anxious anticipation of what would happen during the consultation - what the outcome might be - preoccupied them as they waited in the main waiting room. Crucially, however, this anxiety did not respect architectural thresholds, instead bleeding across spaces and times of waiting. Like participants in Stimson and Webb's (1975: 25) seminal study, 'there were indications that anticipating the interaction with the doctor entailed concern of an emotional nature for some people. Fear of serious illness and its consequences can contribute to feelings of apprehension about the consultation'.

For Antonia, the anxiety of waiting was not about worries of infection but was more to do with the prospect of the genital examination, and the experience of pain:

'I was quite nervous (*yeah*) because again of exposing yourself erm and not knowing, you know, I know that they show you where they're putting it and stuff but you don't *know* at the time what you will be suffering – the pain and stuff'.

Antonia's comment on how she was feeling as she waited picks up on a couple of points. Firstly is the issue of 'exposing yourself' during the consultation – a topic that will be returned to and discussed at length in the following chapter, 'Consultations'. The second point is in relation to pain, and indicates that Antonia was thinking about – perhaps even trying to imagine or prepare for – the unknown pain of the IUC fitting, as she waited for her appointment.

For all of those attendees who were concerned about what was to come in the consultation, it is arguable that their experience of the main waiting room resonated with what Tanner, in her literary study of the representation of medical waiting rooms, suggests when she notes that waiting rooms are often dismissed by those within them as places 'we pass through on the way to somewhere else' (Tanner 2002: 116). In the case of these attendees, their experiences of the main waiting room are preoccupied by the 'somewhere else', a space and time ahead of them on their care pathway.

While, for some attendees, waiting was an emotionally taxing experience, brought about by their 'interior dialogues and emotional life-worlds that derive from a person's current existential concerns' (Irving 2010: 25), others were far less concerned by the time spent waiting upon arrival into the first of the 'sorting spaces'. For Louisa, her conviction that nothing was wrong, had the influence of making waiting less of a concern.

Louisa did not view herself to be at risk and, consequently, described waiting in the main waiting room in the following way:

'I was completely peaceful because [laughing] for me it wasn't nothing stressful. I didn't come for contraception emergency pills, I wasn't raped and nothing like that. I didn't have, uh, some sex without condom so I wasn't afraid. I was completely peaceful (*uh-huh*). My friend as well so we think that we are the only happy people there [laughing]'.

Louisa's comment provides a clear example of how the experience of the landscapes of the facility can be influenced by the emotions people bring to it. She clearly outlines that she was not worried, rather, she was 'completely peaceful'. While not mentioned in the above quote, Louisa's peacefulness was something that she attributed in part to the very availability of care at the clinic, care which was not available to her in Poland. In addition, Louisa noted that because her and her friend were the only happy people in the main waiting room, which she

described as being full of ‘some worried people something like this and some of them were depressed some were crying girls, you know, with tears with their eyes and they are just looking on the walls’, they tried hard to ‘not show that we were happy’. Linking back to the earlier accounts of how Holly, Garry and Antonia experienced waiting as emotionally difficult – on account of worrying about the outcome of their visit to the facility – perhaps Louisa’s example here demonstrates how, without worry, the experience of waiting can be very differently lived.

6.2.6 Becoming admitted: The experience of triage

‘The first procedural rule says that *everybody needs a pass in order to pass*’ (Pütz 2012: 166).

As already mentioned in the description of the main waiting room, booked appointment holders were not required to undergo triage. Their place at the facility had already been secured as a result of self- or GP referral and the wait they experienced for their appointment. For all ‘walk-in’s, however, triage was necessary in order to determine the correct care pathway for each individual, or to turn those away who did not fit the remit of the institution. Here I consider experiences of becoming admitted, starting with what I refer to as the question of legitimacy.

Libby, Maddie and Roisin each recalled to me how they had spent their time awaiting triage reflecting on whether they would be accepted into the clinic or sent away. For each of these women, it was the use of the word ‘urgent’ on the triage laminated card that triggered feelings of doubt as to their right to attend. Roisin recalled what she thought about this use of language, saying:

‘My first reaction, my first reaction was, well, I’m not an urgent case – I’m gonna get sent back and I’ll have to sit here again tomorrow’.

For Roisin – who was asymptomatic and expecting to go to ‘no-talk testing’ (NTT) – the word ‘urgent’ did not relate to her situation. Indeed, Roisin herself did not feel that she was at risk, having attended the facility on her boyfriend’s behest. Consequently, the word ‘urgent’ introduced the idea that she might well be sent away. Despite her concerns, however, Roisin remained in the queue and was provided with a space on the NTT care pathway. Roisin’s

comment does raise a central point: NTT is, by design, a care pathway that is for those cases that are *not* urgent. There is, then, an interesting contradiction in that, while not clinically urgent and at very low risk of being infected or infectious, those attending as asymptomatic are given access to the specialist clinic. As one HCP noted:

‘I think there’s still a bit of difficulty about prioritisation and whose most in need. There’s still a little bit of family planning versus GUM over who, you know. So we’re not meant to see any routine contraceptive stuff, we’re meant to send them back to their GPs. Yet we still have people booked in who could perfectly happily go to their GPs for their STI screening – there’s nothing complex about them, they’ve got no symptoms, they just need a few swabs done and sent. In fact, they can do their own swabs, so they don’t even need a clinician to see them. I would argue that contraception is much more important than whether you check somebody who has no symptoms for chlamydia, but... I think it’s debatable, and I think it is debated’.

The function of NTT, however, can be better understood in relation to what Pryce (2000: 103) says: ‘the individual actor is exhorted to engage in increased sexual and medical self-surveillance and to be recruited in the project of becoming an ‘active patient’’. Thus, despite not feeling at risk, individuals like Roisin have nevertheless recognised an impetus to be tested, and the clinic provides this service readily.

Libby and Maddie also experienced some uncertainty around their place at the clinic when they saw the word ‘urgent’ on the triage card. Having put off getting her symptoms checked for several months (on account of feeling embarrassed and also intimidated by having to attend a sexual health clinic, as discussed in the previous chapter), Libby found herself unsure of her right to be at the facility, while she waited for triage in the main waiting room:

‘I felt like that was like signalling out someone that was like urgent. But I don’t feel that I was urgent but I wouldn’t know where else to go, you know, the doctor or anything, so... yeah, I was a bit worried they might say I had to go’.

Recalling the previous chapter, Libby had noted that the wait for her GP surgery was too long, hence her decision to attend the clinic instead. Now there, she was unsure that she would be seen, causing her to worry about being told that she ‘had to go’. For those who present symptomatic, places are awarded on to the general clinic on the basis of triage assessment of eligibility to the service, and availability of spaces. Libby’s experience was that she felt

unsure of her place at the clinic until she was provided with a general clinic slot and placed onto that care pathway.

Finally, Maddie also had this sense of uncertainty – of potentially being out of place – saying:

M: 'Part of me was worried someone would say well actually you know we're not going to do this today because you're not acute or serious enough for us to do this today. So part of me was worried they were going to send me away'.

S: 'umm, is there anything that made you feel that way?'

M: 'Because it says on the thing it says for acute, urge..or urgent issues..'

S: 'It says on..?'

M: 'It says on the laminated sheet (*oh, ok*). And who determines what's urgent? 'Cause what's urgent to me is not necessarily what's urgent to the general populace of what they see, so I found that difficult to judge'.

In Maddie's case, as we know from Chapter 5 the facility was the only option available to her (or, rather, the only option that she felt was appropriate). Consequently, to then experience the uncertainty of her place at the facility was a source of some anxiety while waiting for triage. Taken collectively, these examples, which span three different presenting issues (asymptomatic, symptomatic and requesting IUC) nevertheless all found the word 'urgent' to be symbolically loaded, providing an example of the affective property of language and symbols within the landscape (Gesler 1992). Considering the essential role of triage, that is, to differentiate between attendees (Lipsky 2010:106), Roisin, Libby and Maddie's concerns were not unfounded. Differentiation – a means of trimming the fat and rationing public services (Lipsky 2010: 39) - is contingent upon staff who are able to assess the appropriateness, or legitimacy, of individuals to the service (Hillman 2014), decisions that are made in line with what Hillman (2014: 487), in her study of emergency department triage, refers to as 'organisational and institutional interests'. In the case of the 'walk-ins' at my field-site, despite the first-come, first-served system, there is no guarantee of a place on the care pathway, as was described to me by a HCP who works on the triage:

'The walk-in process has changed a little bit because it used, we used to see everybody now all we're promising is that everybody will be triaged...you'll get a consultation

with a nurse. If the nurse doesn't think it's appropriate for you to be tested or whatever, or treated on the day, we'll say go to your GP. Or take a personal testing kit, or go to the pharmacy or whatever'.

As the above comment indicates, the first-come, first-served system that did, initially, translate to a guaranteed place at the clinic for those who arrived early, has since been changed in an effort to ensure that those with the appropriate needs get through, rather than those able to arrive early. In this way, the new system of triage means that 'priority of arrival is only a necessary, and not in itself sufficient, pre-condition of access to the service that the queue seeks' (Gray 2007: 169). While Gray, in his study of the 'moral and social geography' of the queue, is referring here to how to maintain one's place in a queue having arrived, this principle could also be applied to triage, as one HCP said:

'It's a better idea. Um, because certainly, it's often the people you need to see who come in the latest; they're the least organised...they've got further to come (*mmm*)...um, so that's good as well that I think that people are more conscious about not sending people away...who, um, maybe are more vulnerable (*yeah*)...more needy...less organised. There's more recognition about that'.

While it can be understood that 'everyone is not equally entitled to public services' (Lipsky 2010: 105) and that 'eligibility... and suitability for bureaucratic intervention must all be determined', most of the participants in my study who underwent triage did not speak of this interaction with the gatekeeper as particularly noteworthy, despite the aforementioned disclaimer on the triage card indicating that access beyond triage was not guaranteed. Considering why this omission might have occurred, I offer three suggestions, based upon attendee experiences. In the first instance, Libby, Roisin and Maddie were new to the facility, and so perhaps their sense of uncertainty was comparatively greater than others who had, previously, been through the triage system. For others, conversely, there was perhaps a sense of certainty in their right to be at the facility, this having been brought about by engagement with other HCPs who suggested they attend the specialist service (as in Louisa's case), or being symptomatic and having used the website to verify that the clinic is the right place to go. Lastly, there were those who were preoccupied by thoughts of what lay ahead. It could be argued that their preoccupation with what the consultation would entail drowned out any other immediate concerns over admission to the service.

Having discussed experiences of the main waiting room and the processes of admission to a care pathway, I now consider the atrium - a vast space at the heart of the facility, passed through by all attendees en-route to the 'hubs' and, later, the consultation rooms beyond.

6.3 The Atrium: A breathing space



Architecture and Design, Scotland, n.d



Architecture and Design, Scotland, n.d

To cross the threshold between the main waiting room and the atrium is symbolic of the fact that the attendee has been successfully admitted into the facility and secured a place on a care pathway. Put simply, the doorway between the main waiting room and the atrium marks the boundary between the public spaces of the clinic (the foyer and main waiting room) and the regulated spaces beyond. As attendee accounts of this space will indicate, however, the aesthetic of this space served not as a reminder of the regulated, private, medical realm into which they had entered but instead, quite contrarily, of open, public, non-medical places such as museums and libraries. This impressive space, which connects the old hospital to its new, clinical extension by means of a structure-length, glass ceiling, allows sunlight to penetrate into this section of the facility that would, otherwise, be without natural light. The function of the atrium, therefore is, in part, to solve an architectural problem.

The atrium is quieter, far bigger in dimension, and calmer in terms of noise and activity than both the frontier spaces (Chapter 5) and the main waiting room. Located in the heart of the facility, sounds do not permeate from the outside to the same extent and, serving as a route to elsewhere, it is rarely populated beyond the trickling flow of attendees making their way to their designated ‘hub’. The atrium has an aesthetic that belies its location within a specialist medical facility, a point that will be elaborated on in attendees’ accounts. The exterior walls of the old Victorian hospital remain exposed, as you can see clearly in the above photographs, and are juxtaposed against the white, modern architecture of the extension. Park-style benches are placed in the grand hallway at the foot of the stairway (although I rarely observed anyone sitting on them). Here, art works, often commissioned from the local art college, are exhibited on the walls at the foot of the stairway. A couple of plants also occupy this space and, during the festive season, a Christmas tree is placed next to the reception desk. The flyer racks that hold information on a number of issues, such as HIV testing, infections, and safe relationships are the only reminder within this space of its location within a sexual and reproductive healthcare facility. Crucially, and unlike the other ‘sorting spaces’ on the journey, the atrium is a space of movement, rather than institutionally mediated stasis.

The function of the atrium, then, is to provide light to permeate the heart of the facility and a thoroughfare to the ‘hubs’ that are situated off this central space. A second reception team are located at the foot of the stairwell, aiding in the sorting of attendees into their appropriate ‘hub’ for their presenting need.

Attendees, having been restricted to the foyer and main waiting room – both *waiting* spaces of temporary stasis which could be busy, noisy and small – found the atrium to be a welcome reprieve. The affect of this space was almost certainly calibrated in relation to the previous spaces attendees had already passed through (Krafl and Adey 2008). Indeed, this might provide an explanation for why the main waiting room was received so well, when compared to the foyer and, further along the care pathway, in the case of the atrium. It was also a space of *movement*; a space that carried them elsewhere, as Maddie suggested:

‘When you went downstairs, that open space by the reception there was lovely, *really* nice. It reminded me of the Chambers street museum (*oh really*). You know, that big atrium bit? (*uh-huh, uh-huh*) It reminded me of that’.

For Maddie – who we know was not at all comfortable in the main waiting room – the design of the atrium took her to a museum. For others, like Rosa, it was the serenity of the space that was noticed:

‘Walking through that door and there’s that very open space (*uh-huh*) I mean it was just like ‘oh, wow’ kind of thing and it was all, it was kind of more serene than I would’ve expected that kind of a place to be like (*yeah*) um, I suppose when I know this part of Edinburgh I know the old hospital when it was here, you know, how it was very much dark corridors and tunnels so I suppose I had that in my head, so it was lovely’.

For both Maddie and Rosa, the atrium was a surprise. Harish also made this point, stating:

‘The whole building itself when you enter the entrance er, looks like it’s a very small sort of like clinic, but’s actually not – it’s quite a huge space ‘cause most of it is all underground erm...and I really like the modern bit which is a newly built area on the ground’.

Over the course of my time conducting fieldwork I heard the atrium described to me in a number of ways. The museum comparison was made by Maddie, then Antonia said that she felt it looked like an ‘art gallery or library’ while Libby felt it was ‘just like a uni building, not a doctor’s’. As Kraftl and Adey (2008: 219) note, although each person’s first affective relationship with the [place] will be different...there are similarities in the affects and affordances produced by such design elements. In the case of the atrium, we can see that, while the places of comparison were different, they were also all the same in that none of them regarded the architectural feature as expected for a health facility. For Louisa, despite not comparing the atrium to any specific different architectural site, the size of the room had a profound effect, giving her ‘just enough space to feel that you have some air to breathe’. Thinking of the space symbolically, Penny suggested that the ‘nice, bright and open’ design was ‘complementary to the open approach to sexual health they have here’. The atrium, however, is a thoroughfare en-route to the ‘hubs’ and, consequently, participants had to pass through it, finding themselves in one of the three smaller ‘hub’ waiting rooms as they once again paused on their journey through the clinic.

6.4 Stage 2: The ‘hubs’



Architecture and Design, Scotland, n.d



Architecture and Design, Scotland, n.d



Author's own

The ‘hubs’, like the main waiting room before it, are places of temporary stasis where attendees are asked to, once again, pause before being called in for their consultation with the HCP. There are four such waiting spaces at the facility, each located off the central atrium, either on basement or street level. The ‘hubs’ are closer in size to the foyer than the main waiting room and intended for a smaller number of people who, by this time in the clinic

journey, have been organised according to their presenting need. ‘Hub’ 1 is used for NTT, ‘hub’ 2 for general clinic ‘walk-in’, and the ‘specialist hub’ located at street level is for booked appointment holders²⁶. Like the main waiting room, the ‘hubs’ are painted in a combination of light, bright hues and block colour on some of the walls. The same objects feature as in the main waiting room, such as magazines and posters. Unlike the main waiting room, however, there is no pop radio and, in general, these smaller spaces tended to be more quiet than the first of the ‘sorting spaces’ – perhaps a result of the more intimate setting stifling conversation, or the growing nerves of those waiting. Televisions are used in these spaces, albeit muted and subtitled, which would provide distraction. As in the main waiting room and the foyer before it, attendees would spend their time engaging with their mobile devices, reading magazines, books or university notes, or simply sit, waiting.

This final part of the chapter considers the ‘hub’ spaces and attendee experiences thereof. By the time that attendees found themselves in their assigned ‘hub’, they were in the final stage of waiting, that is, on the brink of the consultation. The following, concluding part of this chapter considers attendees’ reflections on their time in the ‘hubs’, focusing in on two key themes in their narratives: the spatio-temporal proximity to the consultation and associated effect, and the relative homogeneity of the social landscape of the smaller waiting rooms.

6.4.1 Spatio-temporal proximity to the consultation

As Prior (1988: 89) notes, ‘any analysis of human actors and interaction in space is inextricably linked to an analysis of the ways in which actors and interaction are dispersed through time. Space and time, (*via* the intermediary of motion), are therefore different sides of the same coin’. The following section will consider, then, how attendees experienced their time in the ‘hubs’. As was the case with attendees at an earlier stage of the journey through the ‘sorting spaces’, attendees spoke of feeling anxious while waiting in their allocated ‘hub’. Holly, who had spoken of her generalised nerves in the main waiting room – attributed to ‘anticipation of what it was going to be like’ – reflected on her experience of anxious anticipation while in the ‘hub’ in relation to a now more specific concern: what would come next, the consultation:

²⁶ ‘Hub 3’ is used for the ‘Choices’ abortion service, and so was not part of my field-site

‘I was thinking about how I’ll be treated – things like that (*uh-huh*), just like...mainly irrational things, but I think that’s just me. So yeah, just what would happen’.

While Holly spent her time in the ‘hub’ thinking about what was to come in terms of the interpersonal interaction that would unfold – ‘how I’ll be treated’ – Garry’s concerns were still fixed on whether he had contracted HIV. Saying very little, he fidgeted, biting his nails – a nervous habit I observed in a number of other attendees. As the following chapter on the consultation will show, Garry’s anxiety did not subside when called into the consultation room, instead growing as he faced a HCP who was reluctant to provide him with the PEP treatment he wished for. Taken together, the experience of waiting was, for attendees such as Holly and Garry, a source of anxious anticipation and worry that persisted throughout their clinic journey, in some cases starting before their arrival (as discussed in Chapter 5). Thus, these emotions were seemingly a constant, rather than attributable to any one of the spatio-temporal points on their journey through the ‘sorting spaces’ of the facility. For others, however, change was experienced in the form of increasing anxiety as the consultation approached. Rosa reflected on her time waiting in the various spaces and at different times, saying:

‘It was quieter than I thought it would be, and that made me feel more relaxed. Certainly that first reception area, you know, it certainly was less people around than I envisioned seeing and, well, it just makes you feel better. It was actually just very peaceful coming in. The way it was laid out, made you feel more at ease of what was gonna happen’.

Rosa’s recollection of her experience of the main waiting room indicates a lack of concern, even a peacefulness, which was unexpected. There was no reference to feeling anxious about what was to come. However, things changed once she arrived in the ‘hub’:

‘It’s when you get to being nearer to the consultation, you know, when the doctor will be talking to you when you think ‘yeah, ok, this is gonna happen’. That’s when you start to get nervous, ‘cause otherwise you can almost kind of put yourself at ease, like ‘I’ve just got an appointment for anything’ or ‘I’m just getting my eyes tested’, you know what I mean? But when you are almost there, that’s when the nerves kick in’.

Getting ‘nearer’ to the consultation, as Rosa puts it, in terms of space and time, is recognised as a catalyst for heightened anxiety. This shift was, again, recognisable in Jennifer’s accounts of the ‘hub’, when compared to the main waiting room before it:

‘I don’t know but I think people are quite uncomfortable sitting, sort of waiting, and then one gets called and you think when’s it going to be me? Yeah, I think that gets you more anxious. I mean, up until that last bit of waiting, I was fine, because I’d had a *very* busy morning so I hadn’t had time to think’.

Here Jennifer, in a comment that is very similar to Rosa’s, indicates that it is in the last moments of waiting that nerves kick in. Linking to the social landscape of the ‘hub’, Jennifer notes that watching others – and waiting to be called up, wondering when it would be her turn – amplifies this sense of growing anxiety.

While for attendees such as Holly, Garry, Rosa and Jennifer the ‘hub’ was experienced as a space for anxious anticipation – be it a new emotion or an enduring one – for others it was the social landscape of these smaller waiting spaces that were commented upon, whether as an improvement from that of the main waiting room, or a worsening of the situation.

6.4.2 Being separate: a new socio-material landscape

Harriet, as already discussed, did not like the social landscape of the main waiting room. When speaking of the ‘hub’, however, she indicated her sense of improved comfort, saying:

‘They are controlled spaces, you know? It’s with other people coming for what I’m coming for’.

In a similar manner, Jennifer’s aforementioned comment earlier on in the chapter also made mention of the social landscape of the main waiting room compared to that of the ‘hub’, suggestive of her preference for her perceived homogeneity of the ‘hub’ population. She noted, ‘I think everybody feels more comfortable if they’re in the waiting room for your designated thing, you know?’ It is, in Harriet and Jennifer’s comments, that Foucault’s discussion of discipline and space resonates – ‘each individual has his own place; and each place its individual’ (1977: 143).

The ‘hubs’ were spaces that elicited less commentary in recollection. Considering why this might be the case, I find an interesting reflection in Augé’s story of Pierre Dupont travelling through the airport. Augé (2008: 2) writes:

‘He was enjoying the feeling of freedom imparted by having got rid of his luggage and at the same time, more intimately, by the certainty that, now that he was ‘sorted out’,

his identity registered, his boarding pass in his pocket, he had nothing to do but wait for the sequence of events’.

Of course, there are differences to be considered. Augé’s is the story of an airport traveller, rather than someone attending a health facility with possible associated emotions. Thus, it is not to suggest a parallel, however, there are points that resonate. Considering the experiences in the main waiting room that linked experiences of waiting with feelings of uncertainty of access, the ‘hub’ appeared different in affect. Perhaps one key reason for this is due to participants’ sense of clarity at this point and time on the journey as legitimate attendees (in organisational terms). Furthermore, the heterogeneous social landscape of the main waiting room had been superseded by a more socially homogeneous grouping of attendees according to presenting need. Returning to Augé, and applying his story to the context of the clinic journey, it could be suggested that having been ‘sorted out’, that is, registered, and subsequently given the documents that provided passage through to the more secure spaces of the facility, there is a sense of certainty, or inevitability, that prevails – a simplified wait for events to unfold whereby only personal concerns remain.

6.5 Conclusion

This chapter has provided an account of the ways in which attendees experienced their journey through the ‘sorting spaces’ of the facility. Participant accounts have spoken of the affective influence on their experiences of both the spaces they occupied and passed through as well as the temporal point on their journey. A ‘movement-feeling connection’ has been explored, whereby travel along the care pathway’s constitutive spaces, ‘is a movement through a range of emotions and feelings’ (Adey 2008: 446). In addition, personal concerns and preoccupations have featured as informative, transgressing space and time to influence emotions of waiting. Irrespective of the tone of the experience, it has been shown that ‘the affective quality of the space in which bodies move is never only something personal – it is a product of a complex mix between...light, sound, bodies, gestures’ (McCormack 2008: 1827-1828). As we move on to the following chapter, we follow attendees further into what is arguably the most vital moment of their clinic journey – the consultation.

7. Consultations

7.1 Introduction

This chapter reports on attendees' experiences of the consultation, while also referring to staff narratives in order to provide additional context as to the interactions I observed and experiences that attendees reported. Accompanying a total of 29 attendees²⁷ on their clinic journey, I sat in on 32 HCP-attendee interactions, comprised of: 16 'walk-in' attendees across 'general clinic' and NTT; 13 IUC clinics and; 3 health advisor sessions. These final three account for the additional number of consultations observed, as it was three of the 'general clinic' attendees who were assigned, by the HCP during consultation, to be in need of additional support and intervention. The particularities of each of these 'types' of interaction will be discussed below, however, as a broad brush, 'general clinic' and IUC consultations featured, both, an initial consultation, intimate examination and, where necessary, a medical procedure whereas NTT interactions were, by definition and design, *different* – pared down, without conversation nor examination. Health advisor sessions were mainly conversation-based, but could also feature blood tests.

In Part One of the chapter I discuss attendees' experiences of their specific consultations, focusing on two themes linked to the initial conversation: mandatory questions and confession. Part Two then goes on to reflect on experiences of the intimate examination, medical procedure and the influence of HCPs on experience. Part Three looks at the previously considered demeanour of attendees during consultation, reflecting on this in relation to the affective landscapes experienced en-route to this stage in their clinic journey. Finally, I finish with the exit journey. I open, however, with an introduction to the consultation rooms, offering a description of their materiality as well as outlining the defining characteristics of each of the aforementioned types of consultation. This detail will, as in previous chapters, provide context needed to help understand the discussion to come.

²⁷ 16 'walk-in' consultations, of which 3 were assigned to NTT. Then I observed 13 IUC consultations, with one other being made unavailable to me by the HCP, despite the attendee having consented to participate.

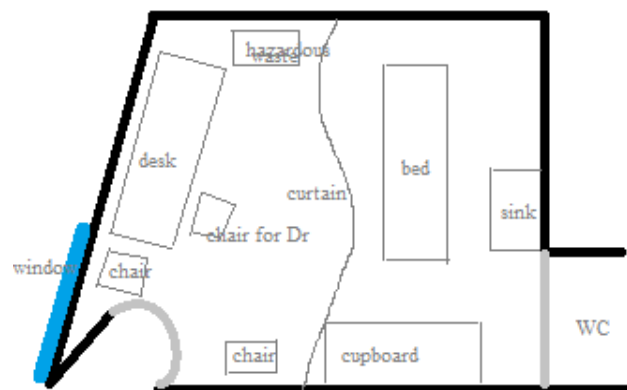
7.2 The consultations: A 'thick description' of space and action



Architecture and Design, Scotland, n.d



Architecture and Design, Scotland, n.d



Author's own

The majority of the consultation rooms are situated in the new wing, to the rear of the building²⁸, indicated in the first photograph above. Rooms for booked appointment holders to the IUC clinic are located on the ‘specialist floor’, where the more invasive procedures carried out at the facility are assigned (SBC 2007: 12). The specialist floor is located directly across the atrium from the main waiting room, at street level. In the case of general clinic, NTT and Health Adviser sessions, consultation rooms are located directly below those on the specialist floor, in the basement of the facility, running the length of the atrium. Taken collectively, then, the room schedule is ‘based on three groups of six consulting rooms with support facilities in the generic area, and one set of six with related support facilities in the specialist area’ (SBC 2007: 12).

All of the consultation rooms are constructed to the standard 16 square meters required for such spaces (*in consultation*: 16-07-2013). Each room contains a workstation for the practitioner, examination bed, sink, supply cupboard, chairs and privacy curtain, as well as many of them having their own en-suite toilet facilities. The specialist floor rooms house additional equipment, including transvaginal ultrasound machines. In addition to the larger objects found, other smaller objects also feature – as would be expected – such as pens, pencils, folders, posters, information leaflets, boxes of latex gloves, hand sanitizer bottles (wall mounted or on the desk), condoms and so on. As Stimson and Webb (1975: 57) suggest, it is these objects, both, specialist and familiar, that might be considered symbolic of the specialist, expert practice that occurs within the space of the consultation room.

Consultation rooms, and the objects found within, become animated places of interaction when the HCP and attendee enter the space and begin their conversation. Having brought the attendee in from the ‘hub’ where they had been temporarily assigned, the HCP initiates the consultation, with phrases like ‘hi, I’m doctor...’ or ‘hello, I’m... and I’ll be seeing you today’, ‘how can we help?’. These greetings, which appeared part of the routine practice of HCPs that who I observed, might be understood as having a dual effect: to introduce the HCP to the individual, and to indicate that, at this time, the floor was open to the attendee to speak, and outline their concerns in their own words. Indeed, none of the attendees I observed spoke

²⁸ The key reasons for their location is that, in the first instance, protected building status meant that walls of the original building could not be knocked down in the renovation. In addition, in order to create a sterile environment that could be easily cleaned, new rooms without original characteristics, such as cornices, were deemed best.

until they were invited thus, it seems, participating in the asymmetrical character of the consultation in which it is the HCP who leads proceedings. Then, the two social actors took on their respective roles of the consultation, the HCP ‘obtaining information necessary’ to provide care and the attendee providing the information needed to aid the HCP in their work (Boydell 2010: 95). As the individual attendee outlined their presenting issue, some HCPs would sit, turning to face the individual, paying close attention and maintaining eye-contact, while others would simultaneously listen while typing notes on to the computer, turning back and forth towards or away from the attendee, as the following excerpt from field-notes from Danny’s consultation demonstrate:

During this interaction, the doctor came across as interested, warm, professional. The body language was one of interest – lots of eye contact and facing the participant. There was no tone/impression of judgement in the interaction. As for the participant, he seemed forthcoming, and did not appear to be uncomfortable talking about his sexual history [28-01-2014].

Certainly, there was variation in the level of engagement the HCP showed the attendee, this spanning those who would, largely, look at the computer while only at times glancing at the individual in the room through to those who would engage exclusively with the attendee before, finally, filing out necessary information on the computer when the individual was otherwise engaged (for example, taking their own chlamydia test, undressing for physical examination, or reading information). Following this, sounds particular to the medical encounter emanate: words spoken; notes being typed; the curtain drawn closed and opened again; clothing being taken off with the accompanying sounds of effort; water flowing as hands are washed before being dried with paper towels; sterile packets being opened, the extraneous thrown into a peddle bin with a metallic clank of the lid slamming shut; gloves pulled on and off, all accompanied by occasional tears or exclamations of pain. How attendees experienced the actions that generated these sounds will become apparent in the coming discussion. Having provided an introduction to the materiality of the consultation rooms – a materiality that set the scene for interactions which unfolded - I now offer a brief description of the different types of consultation that participants were part of and which I observed during fieldwork, before moving on to attendee experiences thereof.

7.3 The consultations: A brief description of their characteristics

As mentioned in the introduction to this chapter, general clinic and IUC clinic consultations involved both conversation and intimate examination and, often, a medical procedure. As such, these consultations were scheduled to last for 30 minutes, and indeed it was not uncommon for them to run over, to 45 minutes, even ‘sometimes up to an hour’ as one HCP noted. These consultations would begin with the HCP handing the floor to attendees in order for them to outline, in their own words, their reason for attending the facility. Once the attendee had presented their reason for attending, the HCP would then follow up with questions, both standardised and also more individualised, before conducting the intimate examination and procedure. Opportunities for the attendee to raise any questions were provided, to a greater or lesser extent seemingly determined by the individual HCP’s practice method, throughout the interaction.

Health adviser sessions were characterised by extensive conversation between the HCP and the attendee but were also used for the purposes of contact tracing and the administration of medication. As Day describes in her study of women working in the sex industry accessing the clinic, health advisers at the clinic are there ‘to discuss contacts, receive advice and possible counselling together with follow up appointments’ (Day 2007: 17). By way of example, in Garry’s case his session with the health adviser incorporated discussion of his fears of possibly being found to be HIV positive, in addition to detailing the schedule of appointments he would have to make over the coming months as part of his PEP regime. Given the broad remit of the health adviser sessions, these consultations, like those of the general clinic and IUC clinic, could last a significant amount of time, 30 minutes or more.

What the general, IUC and health adviser consultations have in common is their structure around the use of both open and closed questions, thus allowing the attendee the space and time to speak about their concerns, raise questions and, as will be discussed later on, negotiate goals. Indeed, as one triage nurse noted, this level of participation was encouraged before attendees had entered the consultation room:

‘We’ll say, you know, when you’re taken into your consultation you’ll get a little chance to chat and you’ll get an opportunity to ask questions that you’re not sure about. And we say, please, make sure you ask the doctor. Don’t just.. you know, just go along with what they say, please ask them, just say that you’re concerned about whatever and be sure to ask them’.

Quite to the contrary, NTT consultations were characterised by their use of exclusively closed questions ('you've come to get NTT?', 'you don't think you are at high risk?') and high levels of HCP control over the proceedings. Intended to last only 10 minutes, the NTT consultation would unfold with the HCP outlining available options and instructions, to which the attendee would simply agree or otherwise. On offer are four tests: HIV, Syphilis, Chlamydia and gonorrhoea²⁹ and the HCP would outline that a blood test was necessary for HIV and Syphilis, while self-administered swabs would screen for Chlamydia and Gonorrhoea. In these NTT sessions, then, there was very little physical touch between the HCP and attendee, with the exception of the touch involved in the drawing of blood. HCPs in NTT sessions would utilise the time when the individual attendee was in the bathroom taking their own swabs in order to complete the necessary administrative tasks: filling out paperwork for the specimens, and adding information to the computer system.

7.4 Part One: Experiences of the consultation

Each of the consultations I observed during fieldwork was, in many ways, unique, the result of the idiosyncrasies of particular interactions between individual attendee and HCP. With that said, there were nevertheless some similarities in what attendees said of their experiences across different types of consultation, and it is to these that I now turn, starting with mandatory questions.

7.4.1 Mandatory questions

Mandatory questions formed a significant part of the information gathering stage of the medical encounters at the general and IUC clinics, while not featuring as part of the NTT or health adviser sessions. Simply understood, these questions marked a shift in the dynamic of the consultation which, in the opening period and up to this point, was characterised by the HCP providing the space and time for the attendee to outline their presenting complaint, to refer to Pilnick et al's (2009: 789) terminology of the conversational structure of the medical interaction. Describing the mandatory data questions to me, one HCP said:

‘There's a whole set of things... called the mandatory data set, and essentially it's the things that we have been told that we must ask every patient, and it must go into the

²⁹ This does depend on time since exposure, as certain infections cannot be detected immediately. For example, the 'window period' for HIV is 4 weeks at a minimum.

system (*ok*). Plus it's the database for the Scottish sexual health strategy. So some of the information we put in is not necessarily directly relevant to what we're doing that very minute with that patient, but it provides an overall picture of data of what is going on in sexual health in Scotland'.

As indicated in the description above, these questions served multiple possible purposes. They were the template with which to provide a standardised consultation, in that – and as the HCP stated – they were questions that, irrespective of the attendees' individual need, must be asked of everyone. In other words, while the consultation was informed by the highly individualised narrative of presenting need, proceedings were not, by any means, to be constrained by this account. One way of looking at this is to suggest that the mandatory questions are a tool for offering each attendee a comprehensive, integrated consultation or, as one HCP whom I observed conduct several consultations put it:

'To me, it's more about holistic (*uh-huh*). Erm, in that erm, you can actually address, you can address everything about someone's sexual health, in one kind of room, one consultation (*yeah*). You don't actually have to deal with it, you know, if it is more complex but you can address them as a whole sexual being rather than as, well okay today I'm gonna do your smear, or you know, I'll screen you for these STIs, or you can have some contraception. But it actually gives you more of a, erm, a window and an opportunity to address other things. So if you're talking about sexual, if they come for a sexual health screening, erm, as a woman particularly, you're gonna ask about their contraceptive, you know, and then you can then introduce that'.

Another HCP reiterated this point, saying:

'I suppose it varies but I suppose what we're all trying to do is not only focus on the initial patient presentation but also explore around that and move onto questions the patient might not actually be expecting about, okay, you're here for your contraception but what about your STI risk and your sexual history or beyond that, your alcohol use, your smoking, or whatever, so I think it comes into, all of that gets integrated in in an ideal consultation when you've got time so it means that it's all in the history, it's in the talk.'

A 'little bit of everything' is achieved with standardised, mandatory questions ranging from general medical history (of disease, such as diabetes, cancer and heart disease), to identify any medications or conditions that might be contraindicated to possible treatments or interventions offered, through to questions about domestic violence ('do you feel safe at home?' or 'is home a safe place?'), rape ('have you ever been raped?') and sexual

predilections ('have you ever paid, or been paid, for sex?'; 'have you ever had sex with someone from overseas?'), these types of questions also noted by Boydell (2010: 97) in her ethnographic study of the pill, and Day (2007: 14) in her work at the GUM clinic. While relating to risk, these questions also link to 'horizontal' care through integrated, holistic services. It is also possible to look at these questions in another way, as a tension between providing tailored, individualized care and the demands of gathering data. How HCPs and attendees responded to these questions will be discussed below.

The mandatory questions appear to be a regulating tool for standardised practice, in that 'we must ask', as the aforementioned HCP noted, suggesting an ambivalence toward the requirement. As part of the 'modernisation agenda' (Nettleton et al 2008: 334), there are regulatory practices and tools, including 'protocols for use in clinical practice' (Nettleton et al 2008: 334). Such protocols might be understood as including the computer-based checklists that clinicians are encouraged to follow in their interactions with patients. Given the broad remit of the integrated consultation, coupled with the integration of HCPs from discrete services, the mandatory questions offer a means to ensure that an integrated consultation is provided by the practitioner. Indeed, as Lipsky (2010:13) notes, street-level bureaucrats (among which he includes 'health workers') have 'relatively high degrees of discretion and relative autonomy from organizational authority'. Therefore, the mandatory questions might be regarded as a tool for mitigating against this. Indeed – and as will soon be discussed - the manner in which some HCP spoke about them, and manipulated them during consultation, is indicative of perhaps small acts of resistance to this prescriptive regulation.

Finally, looking beyond the consultation room and the practice of integration at this site, mandatory questions must be understood as a crucial mechanism for the practice of biopower, whereby we see an attempt, through the collation of data, to generate knowledge that, in turn, can be used for the purposes of managing the health of the population and rendering bodies docile (Boydell 2010: 97; Pryce 2000: 107). As Hirst (1993: 56) notes, referring to Foucault's consideration of power-knowledge in the practice of disciplinary power through surveillance, 'the hospital is not merely a site of care, but a machine of observation – a central institutional condition for the clinical gaze'. In Scotland, it is the National Sexual Health System (NaSH) that is used in consultations to serve as a central database for the collection of public health information. NaSH is described by the system provider as a 'secure clinical electronic

patient record system which supports sexual health services in delivering their strategic service development plan described in the Scottish Sexual Health Strategy – Respect and Responsibility’ (Nisg.scot.nhs.uk, 2016).

As Nettleton (2013: 229) points out, in relation to GP surgeries, consultations have a ‘preventive component’ such as opportunistic screening which goes beyond the presenting problem to the issue of population protection – the act of instituting public health. The same might be said of the integrated consultation in my field-site. Indeed, as Foucault (1976: 24-26) theorised in the first volume of his series, *The History of Sexuality*, ‘in the eighteenth century, sex became a political matter’, linked to population concerns, thus sex became an object for analysis and a ‘target for intervention’. Applying an STS lens to the issue of clinic protocols, specifically, the use of standardised check-lists in abortion service consultations, Benyon-Jones (2013: 109) summarises the link between practice and policy by suggesting that:

‘Such protocols also provide a *physical link* between the contraception/abortion enacted in the clinic and that enacted by policy. Forms such as the one described... do not simply shape the content of health professionals’ interactions with patients. Simultaneously (as health professionals are well aware), they allow information to be recorded about the outcomes of these interactions... and thus participate in policy attempts to evaluate the ‘quality’ of abortion services’.

Having introduced the mandatory questions and HCP views thereof, I now consider how attendees reported experiencing these questions, this structured around two points: irrelevance and confession.

It was not uncommon for women attending the IUC clinic consultations to mention the mandatory questions relating to sexual health and wellbeing, when speaking of their consultation experience in interview. Often, there was a mixture of understanding of the situation, when informed by the HCP that there were some ‘standard’ questions to go through, coupled with a sense of distancing reported in their accounts, as Roz’s comment suggests:

‘I could tell that you must get a wide range of clients into the clinic so I could see why you’d have to cover all the bases and all the questions you’d need to ask so I wasn’t bothered about that at all’.

Here Roz expresses an understanding of the context that gives rise to the mandatory questions – she is aware that other people might come to the clinic with different life stories and,

therefore, the questions need to capture this and, thus, accepted, despite feeling that they are of personal irrelevance. This reading of the mandatory questions as being, both, necessary to ask but also not personally relevant was also expressed by Jennifer, who said:

‘She asked me the questions about have I had sex with women as well as men and this sort of thing – I can’t remember the others – but yeah, that’s fine, you know, that just made me laugh actually so that relaxed me ‘cause, well, for me it’s just ridiculous questions but I know she has to ask them anyway’.

Jennifer’s words indicate clearly her view that the mandatory questions about sexual preference and the like were not individually pertinent (‘ridiculous’) and yet she, like Roz, finds the questions unproblematic, in fact indicating an understanding of the normative practice of asking them and, perhaps, a lack of agency on the part of the HCP to resist – ‘I know she has to ask them’.

For other women, however, the same questions had a more affective influence, as we see in my field-notes on Jules’ interview:

Jules related to me during our interview that the questions had the effect of making her feel ‘lucky’. She elaborated, noting that the questions about whether she felt safe in her own home, or if she had ever been raped, made her appreciative of her own security and wellbeing while simultaneously feeling sadness, brought about by an awareness that those questions were considered necessary [22-10-2014].

In Jules’ experience, then, the mandatory questions stirred emotions in her, as she spoke of feeling, simultaneously, appreciative of her own situation while recognising that there were others who attended the facility that might not be as ‘lucky’ as she was. Jules, like Roz and Jennifer, understood that the questions they were being asked were standard practice and, consequently, did not find them to be problematic.

In the examples of Roz, Jennifer and Jules it is clear to them that the questions were asked for the purpose of checking on, and possibly recording, particular incidents of interest to the state, questions which, consequently, were standardised rather than individualised. These questions were not, however, regarded as unduly problematic by these women. Roz was ambivalent, Jennifer found them humorous and Jules found them emotive. None of the other attendees to the IUC clinic spoke of these questions as being problematic, and all answered them without any objections. This, however, might well have been linked to the manner in which the HCP

presented them which was, often, in the closed-question type format, for example, ‘you’ve not been raped’, and ‘and home is a safe place’. For there was a difference, across consultations in the general clinic and then in the IUC clinic, in the way in which these questions were presented. Indeed, as Jennifer suggested ‘there was about three or four questions that the doctor clearly feels uncomfortable asking’. Observing many different consultations, there were times when the HCP deferred to the mandatory data questions, in an example of what Swinglehurst (2014: 22) characterises as ‘I have to ask this question’, or ‘my computer’s asked me’. Indeed, the mandatory questions, which appear to be a tool for providing an integrated consultation as well as a means to collect population data, also serve as a reminder that ‘one is always caught in the public health surveillance apparatus’, whether as a patient, or a HCP (O’Byrne and Holmes 2009: 66). While some HCPs worked through all of the questions methodically, others spoke of their feelings towards such questioning, hinting at resistance to the practice:

‘We’re supposed to collect a lot of statistics about sexual behaviour and sexual risk and sexual history and hard core drug use, previous abuse, I mean, all these things are relevant but there’s a limit to how much we can deal with and I think sometimes I’m not entirely clear on what we actually do when we dredge up the problem and it’s all got to go on the computer and to me I’m not sure about the balance between how much we’re doing data collection and how much we’re doing patient care. So, it’s... well... we’re supposed to be getting these answers but I’m sure we don’t all... and we don’t always fill in every box. Every now and then we get told we must’.

This sentiment – a degree of disquiet as to the balance between data collection and patient care during the consultation – resonates with Swinglehurst’s (2014: 24) finding in relation to the use of electronic patient records in GP consultations:

‘Additional pressure is placed on clinicians to attend to issues which may or may not be immediately relevant to the consultation. With limited appointment time an inevitable additional institutional constraint, this poses a challenge for priority setting in the consultation or as one GP put it:

“If they want me to collect brownie points then I can...But the patients are being robbed of their consultation”.

In the case of the HCPs in my own research, quoted above, it is clear that there is a degree of pushing back, whereby they perhaps wished to offer an individualised consultation rather than a standardised one, and felt that certain mandatory questions were not relevant to the person

sitting across from them in the room. This practice on the part of some of the HCPs in my research might, then, be interpreted as linked to a desire to protect the therapeutic relationship during the consultation, by avoiding questions which might cause upset. Further, it could be argued that part of the reason that women to the IUC clinic did not find these questions troubling was because of their delivery, with HCPs thus engaged in a form of emotional labour to 'soften' the impact of such mandatory questions. With this said, it was not always the case that there was sufficient understanding between the HCP and attendee to manage the therapeutic relationship during the gathering of mandatory questions, as the following example will demonstrate.

In the general clinic there was little complaint about the mandatory questions. However, one example did stand out. For Heli, the apparent irrelevance of the questions to her situation, coupled with their sensitive nature and the HCP's lack of explanation as to their purpose, functioned to generate a highly emotive encounter, as Heli recalls:

'Urgh... umm... (sighs) I mean it was a bit manic but I think that was possibly my fault more than the nurse I'd say 'cause I was like, 'I want to get out of here, I don't want to answer all of these arbitrary questions'. I kind of wanted to say beforehand 'just don't ask me any of it!' but I know I can't say that (*umm*), erm, but yeah I found it quite stressful that she had to ask me all these questions and, you know, you have to ask fast things like, something like, 'have you ever been *raped*?' asked as like a fast question?! It's a bit like, er... like yeah, I mean, and I don't think I actually answered all the questions honestly to be honest, 'cause like, erm, you know I'm like what does she want to know here? And what do I want her to know here? And what do I care about? Like I want the STD testing (laughing) and I'm going to go for all of it anyway'. She *desperately* wanted to know what other medication I was on and I says what I was on and she's like 'what's it for, what's it for?!' (putting on a shrill, erratic voice) and I'm like 'an anti-inflammatory for muscular pain' and it was like she was really pushing me and I was like, you know, it's not gonna, it's not gonna interact with something you're gonna give me but even if it is like I've told you what medication I'm on, I've told you it's not for, like, sexual health issues, so why do you have to know this? It takes up a lot of time'.

There is a lot to reflect upon in terms of Heli's account of her consultation. In the first instance, Heli did not understand the relevance of the questions she was being asked. This lack of communication and clarity led to a consultation that was frustrating, or 'manic', as she called it. Understanding the potential for such questions to be misinterpreted or poorly received, a HCP explained that it was important to 'explain what you're doing and why with these things'. In Heli's experience, she felt that there was insufficient explanation and, when

compared to other consultations observed, there did appear to be a lack of explanation provided in this instance. Heli's account points to a sense that she was at fault, and that she could not resist the questions being asked of her. With this said, she also admits to what might be regarded as an act of resistance whereby she did not answer questions honestly, in her attempts to subvert this power imbalance, by strategically responding:

'I don't think I actually answered all the questions honestly to be honest, 'cause like, erm, you know I'm like what does she want to know here? And what do *I* want her to know here? And what do I care about? Like I want the STD testing'.

This, then, raises another point about the ways in which not only HCPs, but also attendees, might construct the 'evidence' collected in the mandatory questions. The mandatory questions that formed part of the initial conversational stage of the consultation were multiple in their purpose. They can be understood as a tool for regulating practice, and for guiding the provision of integrated care. They are also, however, a mechanism for gathering data about attendees, for the purposes of epidemiological data collection. As has been discussed, how attendees and HCPs responded to these questions was varied, although perhaps the most surprising observation was the lack of objection to the questioning from attendees. As one HCP speculated:

'I think people perhaps already had the idea that if you asked about contraception then there were other issues that might also come up, or they have been to GU or family planning before and been asked stuff about infection or contraception. So it's not new to be asked other things I suppose'.

So far, I have focused on the mandatory questions in relation to their purpose, in addition to the ways in which, both, HCPs and attendees engage with and respond to them. I now, however, consider the mandatory questions in relation to the practice of confession which, I argue, such questions demand.

In addition to the issue of personal relevance in relation to mandatory questions, embarrassment also came up in attendee narratives. As one might anticipate, the questions that provoked feelings of embarrassment were those related to sexual preference and practice. Harish, attending the 'walk-in' with an itchy all-body rash and having had unprotected sex (although otherwise asymptomatic), reflected on this saying:

‘There were instances when I, when the thought just came into my mind like, ‘I’m saying all this stuff to the nurse – who is a complete stranger as well - but she’s a nurse, (*yeah*), and she’s there to assist me and so I have to tell her. And these are things which I would probably not discuss with many more people (laughing)’.

Harish’s comment about how he has to ‘tell her’ relates – as with Heli – to this idea of confession as a condition of care. Indeed, the mandatory questions demand that individuals such as Harish first confess, or disclose, their private, intimate stories to the HCP in order to access diagnosis and treatment. As Foucault (1988: 16) reflected in his work on ‘Technologies of the Self’ in relation to sexuality there exists ‘a strange and complex way both to verbal prohibition and the obligation to tell the truth’. The genealogy of this, to use Foucauldian terminology, is to be located in the powerful Catholic church of the 17th century that advocated the practice of penance in relation to sexual thoughts and urges (1988:19-20). Harish was not the only attendee to speak of this sense of embarrassment in talking about his sexual activity and preferences. Indeed, Lucille, attending the IUC clinic, also had this reaction to the mandatory questions, saying:

‘I always feel really embarrassed when they ask you questions like ‘have you ever been pregnant’ and you pause and you think, ‘no’ and then you think, ‘why did I have to think? I *know* I haven’t’ (*laughing*) but there’s just so much unusual questions that you’re only asked in that situation (*umm*) and for some reason I get nervous and I think that they think I’m lying [*laughing*] and so I get doubly kind of self-conscious, who knows why! [*laughing a lot*] and um yeah, so that (*ok*) and then – ah yeah, there’s always funny, it always takes me by surprise then ‘cause you’re going in for an IUD, you know you’re married and then she starts asking questions like ‘is your partner male and have you been together long?’ ‘Yes’ and then ‘nine years’ and then ‘and no other partners during that time?’ And I thought, well, ‘no!’ But of course then you realise that they have to ask these things and so it just makes you aware of all the different situations people are in that sit on that chair. But I get so self-conscious during those questions! ‘No, no I haven’t had an affair, actually, now that you ask! [*giggling*] Um, but she’s gotta ask’.

Again, Lucille’s comment indicates her sensitivity to the standardised nature of the questions that she regards as not being relevant to her needs. Despite this objective understanding, she nevertheless says that she feels embarrassed by having to answer (confess) them. Lastly, the health advisor sessions were also a site wherein confession was elicited as part of the interaction. As a reminder, health adviser sessions are for those assessed by the HCP, during consultation, to be in need of further intervention. This decision would be made when the

individual attendee was presenting with behaviour considered to be risky, or where it was considered that contact tracing should be undertaken. In this way, then, the consultation can be regarded as a point for a second triage, assessing risk and trying to reduce risky behaviours (an attempt to instigate transformation of behaviour, then). As one HCP indicates:

‘I send the most complicated patients to health advisers who then could go into it in a bit more depth. So I’d refer someone to a health adviser, ‘cause I’m a bit worried that they’re putting themselves at risk...you just want them to fully understand the risk they’re putting themselves at, and if they still want to do that, then fine, but just... (yeah)... so they actually... they’re actively aware’.

What must be said of the health advisor sessions, then, is that they are a site and interaction for increased intervention, ‘used to counsel individuals about prospective threats to their health that are associated with behaviours deemed to be modifiable. The object is to promote awareness of potential dangers courted by lifestyle choices’ (Lupton 1993: 427). We see, then, an example here of surveillance medicine that is focused on ‘an extracorporeal space’ where ‘the problem is less illness *per se* but the semi-pathological pre-illness at-risk state’ (Armstrong 1995: 401). In their ethnographic study of ‘repetition’ among attendees to a sexual health clinic in Baltimore, US, Leonard et al (2007: 154) note that ‘repeaters’ pose a significant public health concern for practitioners with this ‘core group’ of attendees extending the life of pathogens within the social body through their risky sexual behaviours. As such, they continue, it is these ‘repeaters’ who are targeted for interventions which are designed to change the behaviours of individuals in the name of protecting the health of wider society (Leonard et al 2007: 155). The health advisor sessions that I observed appear to have mirrored this practice somewhat, focusing on gay men with symptoms of infection, or reports of high risk behaviours (Danny, Garry, Joe, and Samuel). It could be argued, then, that these individuals were ‘risk profiled’ by the HCP during consultation, in a form of second triage, and were assigned to the health advisor for further intervention based upon epidemiological and clinical research that allocates a risk measure to individuals (Rose 2001: 8). Yet, this further intervention was not viewed by Danny, Garry nor Samuel as coercive, controlling or discriminating, with each of these individuals speaking of the benefits of the somewhat pedagogical health advisor sessions. For example, Danny made a poignant statement about the role that the health advisor had on his wellbeing, saying:

‘And you saw in my meeting with the health adviser how much she listened (*uh-huh*). She asked the kind of questions that I felt I could open up and it’s nice to have that and I find that a positive aspect, like I find that really helpful. They get a better understanding of why I might be getting STIs and that helps me, like at the moment I feel a bit more lighter, like the weight’s been lifted, I’ve got some of my emotion out just by talking to her about my sexual stuff. Like I don’t, like I tell my friends I have sex like ‘oh, I had sex with such a hot guy’ but I don’t go into the depths like ‘oh, I felt lonely’ (*uh-huh*) ‘I had someone over and had sex to feel better’. Like I don’t go into that depth. I make more of a running joke of it (*umm*). But here they kind of, they don’t empathise, but they sympathise and try and understand me better (*uh-huh*). And I find it, like, helpful’.

Danny clearly has a positive view of the health advisor sessions, despite the extra time waiting that this entailed. It did not appear that Danny experienced the health advisor sessions as being in any way other than supportive of his needs, thus presenting a clear example of how these sessions can be two things at the same time: disciplinary and caring. As Pryce (2000: 107), referring to observations from his ethnographic study of a GUM clinic and the social construction of male sexuality therein, notes, it is the health advisor sessions that elicit confession but bring with this a possible catharsis. Danny’s account of the positive experience he had in the session with the health advisor certainly speaks to this.

7.5 Part Two: Experience of the intimate examination and/or procedure

‘Over the course of a medical examination, certain...boundaries are peeled away to permit a close inspection of parts of the body. At the same time, other boundaries are introduced. Thus persons to be examined are put into a closed room so that its walls substitute evidential boundaries for the clothes they take off, the difference being that the physician is inside the boundaries along with the person’ (Young 1997: 11).

Having discussed attendees’ experiences of some of the features of the initial consultation, I now turn to consider how they spoke about the examination stage of the medical encounter. The majority of attendees experienced intimate examinations as part of their clinical encounter, having to expose ‘parts of [their] body’ – to refer to Young above – to the HCP, be it for gynaecological examination, or inspection of the penis and/or anus for signs of infection. In comparison, those to NTT were not required to subject themselves to this intimate examination, instead instructed to take their own swabs for GC and CT whilst in the privacy of the en-suite bathroom. Here I consider attendees’ reflections on experiencing or

not experiencing the examination, organised under the topics of pain and embarrassment that attendees spoke of.

7.5.1 Pain

While the experience of pain or discomfort was not universal among attendees, it was nevertheless a common feature. For many, the drawing of blood proved to be if not painful then unpleasant, expressed through facial grimacing, turning away from the needle, taking long in-breaths or, the inverse, holding one's breath. When it came to the intimate examination, sounds emanating from behind the curtain were often suggestive of passing, momentary discomfort or pain. Of the four different types of consultation I observed, however, it was in the IUC clinical encounters that pain was unambiguously present in the experience of women undergoing this invasive medical procedure and, consequently, I draw all of my illustrations about pain from IUC examples. As will become clear in attendees' accounts, despite the pain involved in the procedure, women expressed an intention to endure it and, in this way, pain was understood as being worth it. Considering aforementioned reasons for attending the facility, it is perhaps not surprising that women who had waited for months for the procedure, and who had a keen interest in regulating their fertility, would persevere through physical discomfort.

Prior to the medical procedure, the HCP would always warn the individual woman of the potential pain involved in the fitting of the device, thus acknowledging the probability that 'the instrumental gestures of the gynaecological examination [might] cause pain, ranging from discomfort, a sort of eeriness of the interior, to torment' (Young 1997: 53). With this said, HCPs rarely used the word 'pain', instead opting for euphemisms, such as 'nippy', and 'uncomfortable' – a means to, perhaps, warn women, without causing alarm. In order to offer an option to dull the pain, the HCP would give the woman the choice of having a local anaesthetic, injected directly into the cervix, prior to the fitting. Most of the women I accompanied to their IUC consultation did not opt for the anaesthetic, with Marianne suggesting it would only add to the unpleasantness of the experience:

'It was going to hurt either way, and the idea of having a needle put in there is just horrid. So I thought, just grin and bear it'.

Marianne's final remark – 'just grin and bear it' – is something that I will come back to when considering the similarities in women's accounts of their experiences of pain during their IUC fitting. Indeed, in reflecting on the utility of the anaesthetic in relation to the pain experienced by women during the procedure, one HCP noted that it was '6 of one and half a dozen of the other'.

Also deciding not to have the anaesthetic injection, Jennifer nevertheless felt comforted by the warning of pain that the HCP gave her, saying:

'I think, for me, it's being armed with information and so she describes it in quite concise detail, you know, there's going to be a pain, you know, going through the procedure. Maybe some people don't want to know that but I absolutely want to know what's coming at me, you know, I don't want to get, you know, some sort of quite acute pain and not realise what...but the fact she said it's going to be 'sharp' and I actually thought it might be longer than it actually was – in fact it was only for seconds, you know, but the fact that she's talked me through it, it means there's no surprises and that's what I like'.

As Jennifer recounts, her experience was not as bad as she had anticipated with the procedure being over after what she understood to be mere 'seconds'. Being talked through the process was also a comfort, as Jennifer clearly wanted to know what was happening. Speaking of the impact of the HCP on her experience of the procedure, Jennifer said:

J: 'The doctor was lovely – very reassuring. Offered me local anaesthetic, which I didn't need, but the offer was there so'

S: 'Ah ok, so that offer, how did that make you feel?'

J: 'Yeah, it reassures you 'cause you think that if it is uncomfortable for you then there is the option of that and that's a good thing. I think she was *very* good and very reassuring'.

Indeed, listening from the other side of the curtain, Jennifer said very little, despite making affirmative sounds to indicate that she was listening to what was being said by the HCP. At the end of the procedure, Jennifer said thank you, and expressed relief that it had not been as bad as she had expected.

While Jennifer felt that the experience was not as painful as she had anticipated, others like Ivy and Georgia found the procedure to have been very painful, even unexpectedly so. The

following excerpt from field-notes taken during her fitting describe what happened during Ivy's procedure:

The HCP says that she is about to fit the clamp onto the cervix – something that might be a bit 'pinchy'. There is no sound, so the HCP asks whether Ivy is ok. Ivy says 'yes'. It seems from how things are going that Ivy is doing fine with the pain – as she anticipated – but then all of a sudden, a moment after the HCP says that she is about to put the sound in to measure for the device, Ivy exclaims 'oooh!' It comes out of the blue, so unexpected, and so loud. It is clear that she found something very uncomfortable, and both the HCP and the CSW take a moment to ask her how she is. Almost immediately Ivy is saying 'sorry', 'so sorry'. She says that she's fine, and that she was just taken by surprise with the feeling of the sound going in. The HCP tries to reassure her and says that the fitting of the IUS will not be any more uncomfortable, but that it will feel the same. Ivy then just makes another 'oooh!' sound. The HCP says 'well done' and 'continue to breathe' [23-09-2014].

Recalling her experience, Ivy said:

'But jeez, oh! My bum came off the table! Honestly. But it was, what, ten seconds really, it was just a really...it was fingers-down-the-blackboard pain – I can't really explain anything else'.

Ivy's description of the pain she experienced during the fitting is unequivocal – 'fingers-down-the-blackboard pain'. Considering the responses to this expression of pain, the HCP and the CSW both tried to reassure her, indicating that the pain should not become any worse and that the procedure was almost over, as the above excerpt from field-notes attests. When Ivy, again, expressed the pain that she was experiencing, the HCP instructed her to keep breathing. On her part, Ivy simply continued to apologise. Wondering why she kept on saying sorry for her expressions of pain, I asked her about this during interview, to which she said:

'Because my pain threshold is generally really good. And she was like, do you want an anaesthetic, and I was like, oh, shucks, no. And so I just felt embarrassed, like I'd really overshot it. And I thought, after I'd yelped in pain, I'd said to them, look, I won't be a problem, I won't be a problem, I'll be absolutely fine, I won't be a hassle to you. And then obviously clearly I was, because it was way worse than I thought it was going to be. So, yes, I did apologise because I just felt a little bit... that I felt sorry for them because I mean they were both of them like... Just wussy. Definitely. Definitely. And that's not what they think. Because, I mean, as much as I need the service they've got a job to do, you don't want to make their life difficult; if you can

be in and out and be the least problematic a patient as possible then you kind of go away a bit happier, don't you, it's a long day. So, yeah, I just thought, what a shame. And also there is that bit that you don't want them... like, once you've gone, that it's like, oh, my God, she was pathetic, that girl. And so I was a bit embarrassed'.

Ivy's reflections on her expressions of pain during her procedure indicate a keen wish to be an unproblematic patient, one who brought no fuss and who allowed the HCP to get on without disruption. Ivy was embarrassed, then, perhaps because she was unable to suppress 'the audible form' of her pain (Young 1997: 53).

Georgia's experience also hinted at the idea of not wanting to be a problematic, or difficult, patient. Despite experiencing a drawn out procedure on account of her cervix going into spasm, Georgia remained compliant:

The anaesthetic was administered and they waited another minute or so for it to take effect. At this point the HCP proceeded with trying to get the device in. The anaesthetic would allow for her to stretch the cervix, without too much added pain. However, the HCP was struggling to get it in. Asking Georgia how she was doing, Georgia just kept saying, 'I'm fine thanks'. The HCP joked that she didn't have to say 'thanks' and that, instead, she could shout and swear if she wanted. But things remained calm with Georgia making very little noise at all. After some time, the HCP began to introduce the possibility of not being able to do it and calling an end to the procedure without getting the device in. It was interesting to see how this suggestion of potential failure was introduced, and how the CSW also started talking about it, saying things to try and lessen the blow of it not being successfully fitted. As this conversation is taking place, however, Ruby, the HCP, suddenly says 'it's in!' and there are sounds of relief from everyone [04-09-2014].

In Georgia's case, then, the fitting took about 15 minutes – 10 more than she had been expecting, based on the HCP's estimation of five minutes. During the procedure, Georgia said very little although – and as picked up on by the HCP – she did continuously say 'thanks'. Considering this use of language, despite the protracted procedure and the discomfort involved, I asked Georgia to explain, to which she said:

G: 'It was highly uncomfortable but it wasn't painful. I think pain for me is something that is intolerable and that wasn't. I could have taken a lot more of that because the end result would have been worth it'.

S: 'Okay. So, you were motivated to endure it?'

G: 'Yes. I would rather just lie there, suffer, and have it over with. So I am extremely grateful to that doctor for persevering because she could have easily just said, oh, this is not going to work, we'll give up and she didn't and I'm really glad she didn't because she got it to work in the end'.

Georgia says 'she got it to work in the end', this point perhaps hinting at a reason for her passivity in the consultation: not making a fuss, expressing too much pain would allow Georgia to get the outcome she wished for - IUC. By not making a fuss, she kept the HCP on side, and trying. Both Ivy and, albeit to a lesser extent, Georgia suggest that they wanted to be good, unproblematic patients, this despite the discomfort that they experienced during their procedures. Ivy repeatedly apologising for her expressions of pain, and Georgia saying 'thank you' throughout the difficult fitting of her device both indicate this point. When reflecting on this notion of being a good patient, Ivy said:

'Because, I mean, as much as I need the service they've got a job to do, you don't want to make their life difficult; if you can be in and out and be the least problematic a patient as possible then you kind of go away a bit happier, don't you, it's a long day'.

Here Ivy demonstrates a concern for the HCP's experiences of her as a patient. Ivy has aspirations to be 'the least problematic' patient and, consequently, felt embarrassed that she was not able to achieve this goal. In both Ivy and Georgia's example, it is clear that, despite the corporeal 'tugs, disturbances... from [their] remote interior', to refer to Young's (1997: 51) consideration of the perceptual modalities of the gynaecological examination, both wished to make the experience easy for the HCP. This might be understood as a display of remarkable consideration founded in the influence of the 'ideal patient' discourse, or as a symptom of docility that is engineered by the confluence of influences, including personal motivations to attain care, and the disciplining role of the institution and its constitutive landscapes of affect – these points to be expanded on in Chapter 9.

When considering the experience of pain involved in the IUC procedures that women endured, it is worth noting that, despite expressions of pain to which I was witness, none of them asked to stop - all persevered. For these women, then, the pain involved in the procedure was perhaps viewed as unavoidable, something to overcome, worth it for the desired outcome of fertility control and regulation. More could be said about this tolerance of pain. Bendelow (1993: 289) reports in her research on pain perception and gender that 'female

hormonal and reproductive functioning and the role of motherhood were strongly felt to equip girls and women with a “natural” capacity to endure pain’. Of course, this ‘natural’ capacity is a social construction, within a context where there is a socialised female contraceptive burden. Indeed, it is ‘the bodily burdens of heterosexuality which has accompanied the development of contemporary contraceptive technologies... focused on female bodies (e.g. intrauterine devices, oral contraceptives, implants)’ (Benyon-Jones 2013: 110). Yet, the women in my study more often than not viewed LARC, and their opportunity to be fitted with this form of contraception, as a privilege, this despite the physical pain they endured as a result.

Helping women through their experience of pain were the HCPs and CSWs involved in their care. Women often spoke of the positive impact on their experience that the CSWs had had, as Gemma recalled:

‘Yep, so the nurse was amazing so I think if the nurse hadn’t have been there it would’ve been quite difficult because, erm, yeah, she was amazing. She just stood by my side and just got me engaged in conversation (ok) so much so that a few times the doctor had to say to her ‘nurse, nurse’ ‘cause they were wanting her to take something or do something and she was just chat, chat, chat to me ‘cause I was chat, chat, chat to her and that helped ‘cause it was really uncomfortable and, erm, I was just completely focused on talking to her so she was fab’.

Gemma, who we know from previous chapters was attending the facility on account of her GP surgery being unable to offer her the IUC procedure, found the diversion tactics of the CSW supportive through an experience that she found ‘really uncomfortable’. Indeed, CSWs were part of the IUC medical procedures as a matter of course, and provided support to those who were ‘living with and through what [was] happening to their bodies’ (Lawler 1991: 29). CSWs would engage women in conversations about their families, the weather, and so forth and would often offer to hold the individual’s hand. Providing a reason for this, one CSW said:

‘We do that with any patient (*yeah*) when we go in there just ‘cause it’s not a nice position to be in in there. You’re getting stuff done and that and some can get quite upset (*yeah*) so... and it’s, like I’d rather have somebody to talk to – they just want somebody to hold their hand (*uh-huh*)’.

This emotional labour, to refer to Hochschild (1979), was evocative, by which I mean that the CSWs would routinely try to elicit happier emotions from an anxious attendee, through maintaining with the woman ‘a state of talk about something other than the examination throughout its course’ (Young 1997: 52). Ania remarked:

‘It was quite nice having such a super friendly nurse because there was nothing wrong with the doctor’s approach to me but it just wasn’t, just wasn’t friendly. It wasn’t unfriendly it was just very much ‘I’m here as a doctor’ and, yeah, it was just super nice that there was a super friendly nurse there ‘cause they kind of worked well together [laughing]. Um, it wasn’t, there was no unpleasantness, it was just it was very much kind of by the book sort of thing and not too much of the kind of friendly sort of putting yourself at your ease sort of interaction that kind of you get in some places (yeah) but it was fine and then and again it was really nice having the nurse there as she just kind of chatted away to me about, kind of, hobbies or whatever, just good distraction techniques when you’re getting any of these kind of things done. Um, and then she just slipped away quite discreetly just while we finished off with the doctor but I did see her when I was leaving again ‘cause she was back round at reception so I was able to say thank you very much to her when I was on my way out because I really did appreciate her being there. It was good’.

What we see is that while ‘the gynaecologist constructs the realm of medicine visually and tactually’ (Young 1997: 63) it is the CSW who ‘at the same time verbally constructs another reality conjointly with the patient. The patient participates verbally in the construction of this joint reality while she is tactually tugged into the medical realm from which she is visually excluded’ (Young 1997: 63). More critically, this point is discussed by Frankfort (1972: xii), who suggests that the use of the sheet to cover the woman below the waist during the procedure ‘not only depersonalizes the woman by making her faceless and bodiless except for her vagina, it also prevents her from seeing what the doctor is doing’. This provides a clear example of the ‘emotion work’ carried out by the CSW in the IUC clinical encounter, whereby there is a hierarchy of roles, as expressed in Ania’s example, with the HCP conducting the procedure while it is the CSW who engages the attendee in conversation, in an effort to try ‘to change in degree or quality an emotion or feeling’ (Hochschild 1979:561).

7.5.2 Embarrassment

Embarrassment was a common feature of attendees’ reflections on their clinical encounter, most specifically around the intimate examination (although, as already mentioned in Harish’s account, the telling, or confessing, of practices could also be experienced as embarrassing).

This embarrassment during the intimate examination was linked either to what Lawler (1991: 111) calls ‘the act of undressing’ or to bodily appearance, even smell. Taking the issue of undressing as a starting point, it was common practice for the individual attendee to be instructed by the HCP to move behind the curtain to undress, during which time they would be alone – the HCP and, if present, CSW waiting until the attendee was ready before transgressing, beyond the curtain and starting the procedure. Through this choreographed event, ‘any suggestion of sexually defining the situation is deliberately excluded, rather, the encounter is constructed as a professional event’ (Lawler 1991: 111). Similarly, Pryce (2000: 297) notes of the GUM clinic, ‘the GUM clinic is the professional medical arena where the erotic (rather than the disease that might result from sex) is the troublesome contaminant that is ‘out of place’, Pryce taking here from Douglas’ (1966) influential concepts of dirt as being ‘matter out of place’. It is evident from the practices I observed at the facility that every effort was, indeed, made to de-sexualise the intimate examination and to reconstruct intimate touch as highly medicalised, ritualised and sanitized. Despite this practice, however, Lucille found the protocol to be insufficient in terms of allaying her embarrassment at the situation:

‘I’ve got no knickers on with my feet in stirrups and the nurse is sitting there and she was standing at an angle where I felt that she could probably see and I, I was, I didn’t feel like the cloth covering me was covering me. I was really self-conscious about that (uh-huh)’.

In Lucille’s case, then, she felt that the ‘nurse’ (the CSW) was able to see below her waist and this was cause for an uncomfortable experience. While not finding it problematic that the HCP had ‘visual and tactile’ access in order to conduct the IUC procedure, Lucille was concerned that the nurse might also be able to see below the drape. Being visually excluded herself from what was happening below her waist, Lucille relied upon her tactile senses to try and establish the extent to which she was covered, resulting in what Young (1997: 59) calls ‘the split subject’. Unsure as to what was or was not on view, Lucille found the experience of being in the stirrups uncomfortable. Danny also recounted feeling a little embarrassed about undressing prior to his intimate examination - ‘it’s awkward for a little bit - it’s all fun and games and you know’, as did Roisin who said:

‘I didn’t realise I was going to be able to swab myself - that was a nice relief because that’s one of the reasons I’d been putting it off for so long. Yeah, no-one wants to drop their trousers’.

Roisin's comment is important, as it points to a clear reason for why she had been putting off attending the clinic for several months: she did not, in the words of Young (1997: 52), to peel away her clothing and expose herself to 'close inspection'. Learning that she would be able to take the swab herself was a relief, and something that she felt they (the facility) 'should advertise better'.

In addition to the awkwardness of being undressed and partially exposed to the HCP - as was the case with many of the participants in this study - there was concern voiced as to the appearance of the body during the examination, and the smell. As Maddie was changing and getting ready on the bed, she exclaimed 'oh no, I've got really smelly feet!' Ivy, also as she settled on the examination bed, expressed that she wished she had 'shaved her legs', feeling that she should be somehow more groomed for the procedure. In both instances, these expressions of self-consciousness were countered by the CSW and HCP, who tried to reassure the women that these concerns did not matter. In Ivy's case, the CSW even disclosing that she herself was 'between waxes'. The result of this reassurance, in Ivy's case, was that:

'I just felt really comfortable with them both. But I think that's what you need, isn't it, when you are dealing with intimate parts of your body; I'm not young, I'm not slim, so you are a little bit... But, you know what I mean, there is that slight intimidation, isn't it, because neither of them were supermodels, do you know what I mean... quite normal looking girls; so I just thought they were really nice. I'm not looking for a bezzie, but for the role that they were, it was totally that I was not in the least bit uncomfortable with either of them'.

While the curtain served to block my view of the woman's body and featured as a symbolic reminder of the need to divert one's attention elsewhere, the problem was that 'sound is no respecter of the privacy curtain' (Rice 2013: 41). 'Sound moves under, over and through these screens' (Rice 2013: 41). Consequently, I heard – over the course of these examinations – a wide variety of conversations, expressions of pain, laughter and even, on one occasion, crying. Indeed, as Georgia said in her interview, 'well, you know, you could hear what was going on. It wasn't very pleasant'.

In this section on the physical examination which many of the participants in my research underwent, I have shown that, despite finding these experiences embarrassing, and at times painful, attendees nevertheless reported to me that their consultation had gone well – statements that my own observations attest. Attendees were more often than not compliant,

thus aiding the smooth running of the interaction and practices, this compliance not least supported by the emotion work undertaken by staff members during the consultation. Yet, as we move on I suggest that we need to reflect on the transformative and affective landscapes of the facility – discussed in Chapters 5 and 6 – in order to better understand attendees’ tractable demeanour during their consultations.

In this chapter I have considered attendees’ experiences of the consultation and, in this, it has been apparent that most participants adopted a tractable demeanour. It was rare for individuals to challenge HCPs and they would even, at times, apologise for expressions of pain and discomfort, or for feeling upset. In this, it was perhaps a combination of normative expectations of submission to medical knowledge, combined with the individual’s desire to secure the intervention they sought, that worked to discipline their behaviour. In addition to these influences on attendees’ demeanour, I would add the role of the building itself and its affective landscapes. Street (2011: 13) notes that, ‘as “walk through machines”, buildings are artefacts that have a built-in capacity to structure experience’ and, indeed, foster transformation of sorts. In the case of my research, the transformation is one of adaptation, from active consumer to the cooperative, perhaps even passive, patient that I observed in almost all of the participants. For these attendees only reached the consultation room by virtue of having spent time waiting in, and passing through, the spaces of the facility. These spaces were subject to the affective influence of organisational and surveillance practices that, supported by architecture, were intended to be disciplinary (Foucault 1977). Indeed, in terms of the disciplinary power of buildings, it is Foucault who alerted us to the idea that ‘discipline proceeds from the distribution of individuals in space’ (1977: 141). In the case of the clinic, attendees are, from the point of arrival, subject to organisational practices of sorting and categorising that are themselves aided by the use of disciplinary space. Attendees enter a liminal role as they become - for as long as they are in the building – patients, with all of the social norms and obligations which accompany this role, most notably perhaps the social mandate to comply with medical advice and acquiesce to (invasive) procedures. It is perhaps the transition into the building from the outside and the experience of being sorted and categorised that aids in the experiential shift from ‘person’ to ‘patient’. The disciplinary role in shaping attendees’ demeanour is explored further in Chapter 9 (Discussion).

7.6 Part Three: Leaving

With the examination over, tests completed where necessary, and the individual having put their clothing back on 'behind the screen' (Lawler 1991) the consultation would draw to a close, the HCP outlining information that was pertinent (for example, in the case of IUC, to check for device threads). In addition, the attendee would be asked if they had any further questions. More often than not there was little in the way of questions from attendees, instead seeming keen to leave and, often, expressing thanks for the consultation as they exited the room. Indeed, it seemed from my observations that, for the most part, consultations unfolded smoothly, the HCP and attendee working together (if at different levels of participation) to achieve an agreeable outcome for both parties. This ending of the consultation, then, mirroring what Stimson and Webb (1975: 67) observed - 'the words of the farewells, like the greetings, are so routine as to be barely distinguishable. The patient may offer thanks and the exchange of goodbyes may be intermingled'.

When back in the corridor of the clinical floor, signs show the way to the exit of the facility, comprised of a small corridor which leads back into the foyer and peripheral spaces of entry (see photos below). Passing through these spaces and back onto the street outside the facility takes only moments - a stark difference to arrival when, in the case of those attending the 'walk-in', waiting was almost inevitable.



Photographs are author's own

7.7 Conclusion

This chapter has focused on participants' experiences of the consultation, a space and time wherein 'disciplinary power and forms of lay knowledge and expertise' meet (Pryce 2000: 104). In addition to attendee experiences, we have seen how the implementation of care in the consultation can be simultaneously understood as 'examples of panopticism', whereby the mandatory questions and tests, along with risk assessments and talk interventions, can all be understood as disciplinary techniques to render bodies docile (du Plessis 2013: 431). Yet, as we have seen, attendees often reported experiences within the consultation as positive and, perhaps most striking, was the manner in which attendees were passive in their interactions with the HCPs. I have suggested herein that this cooperation in the consultation might be better understood through consideration of the affective landscapes through which each attendee had journeyed en-route to their consultation with the HCP. The Discussion will take up a further issue – that of socially mediated desired outcomes and associated compliance, thus looking beyond the space of the consultation towards broader social discourses around personal responsibility and stigma. As we move on to the Postscript, I turn to consider: how

participants reflected in the immediate aftermath of their time at the clinic; the extent to which their experiences were influenced by the integrated status of the facility and; the reasons they gave for taking part in the research.

8. Postscript: Reflections on a journey

8.1 Introduction

This chapter marks the end of the clinic journey. Having already discussed in some detail participants' accounts of anticipation and arrival ('Beginnings'), registration and waiting ('Admission'), and the clinical consultation ('Consultations'), this chapter focuses on two further considerations: the ways in which attendees found meaning³⁰ in their time at the facility and the extent to which attendees understood the facility to be integrated. In addition, I offer some insights as to why participants took part in the research in spite of my expectations that recruitment would be difficult.

8.2 Part One: The meaning of the clinic visit

Here I consider attendees' reflections of their time at the facility, thoughts which were shared with me during the interview following their consultation. Chapter 5 outlined participants' reasons for attending which spanned the desire to manage risk, for self and society, and the desire to regulate fertility. Here I reflect on the ways in which participants spoke about the influence of their time at the facility in relation to these presenting issues.

8.2.1 Recalibrating risk perception

For some, their time at the facility appeared to bring with it a welcome sense of recalibration of risk perception. Lupton (2013: 636) recognises 'the movement back and forward between feeling 'at risk' and feeling 'safe' that people may experience and the dynamic and heterogeneous contexts in which risk understandings are constantly configured and reconfigured'. For many of the participants in my study, it appeared that – if not a back and forth – there was a linear movement from feeling anxious about risk that was mitigated through contact with the HCP. Thus, we see that risk perception is contingent upon the 'interactive phenomenon' that is risk itself (Adams 1999:4). In the case of attendees in their interactions with HCPs, it was this face-to-face communication that served to recalibrate risk

³⁰ As a reminder, 'meaning' is, throughout the thesis, understood in line with Maxwell's (2012: 30) definition: 'cognition, affect, intentions, and anything else that can be encompassed in what qualitative researchers often refer to as the "participants' perspective".'

perception. Yet, as Garry's example below will demonstrate, this was not always a straightforward process.

As mentioned in Chapter 5, we know that Garry had come to the facility in a state of heightened anxiety, believing that he had put himself at risk of HIV. During the consultation, he was able to successfully negotiate for the treatment that he desired. Reflecting on this as we exited the facility together, he said:

'You know I've been so stressed about this – like sick at the weekend, feeling numb...I don't understand why it took so much effort to get it, like, why she wouldn't give it to me, but now I've got it, I should be ok, I hope'.

Although Garry's commentary on the significance of securing PEP may not seem effusive, it must be understood in the context of the consultation and his chat with the health advisor, during which time he clearly felt that he had most likely contracted HIV – this despite the HCP's attempts to alleviate his fears with epidemiological facts. During the consultation, then, there was a tension between Garry's perception of risk –informed by public health messages – and the HCP's. Lupton argues, (1993: 433) 'the discourse of risk is weighed toward disaster and anxiety rather than peace of mind. Rather than inform the public, for example, that the probability of not contracting HIV in a single sexual encounter is 999 out of 1000, the focus is placed upon the one in 1000 probability that infection will occur'. Reflecting on the issue of public health messages and differing perceptions of risk they generate, the HCP who saw Garry reflected:

'I think the difficulty with public health messages, you have to try and catch everybody, so with a lot of the big, kind of, scary things you get a lot of worried well...(yeah)...who have seen it and have thought, oh, actually I could have that...(yeah)...so I need to go and see somebody. So people can...a lot of people who...when they're actually at risk can identify with it, and that means that you're more likely to catch people who are actually at risk when they come in. But that's the toss-up, between this is really important issue that we need to make sure it gets as wide as possible...(yeah, yeah)...and yes, we have to accept that people will get worried and come in and then at least we can reassure them...(yeah)...but we will make sure that the people who actually need us can...will come in as well'.

Garry had convinced himself that he had contracted HIV, and spoke with significant alarm to the health advisor about how he could 'never, ever tell' his family or friends that he had it. Put simply, Garry anticipated a HIV positive status that would result in having to live in

secrecy with the illness, this not dissimilar to the practices of secrecy reported by Carricaburu and Pierret (1995: 72-73) by both gay men and people with haemophilia, following HIV diagnosis. In Garry's opinion, a diagnosis of HIV was a very real possibility should he not be provided with PEP, and would fundamentally alter his 'sense of identity, and of future potential' (Jutel 2015: 849) in terms of familial and friendship bonds. This anticipated biographical disruption (Bury 1982) caused Garry's anxiety in the days leading up to being prescribed PEP. With this in mind, the words 'I should be ok, I hope' should not be dismissed, for this hopefulness was absent in the long weekend between the event that triggered his anxiety and, finally, receiving clearance to be put on the course of PEP.

Another attendee for whom it was clear that their time at the facility, and with the HCP, was significant in shifting their perception of risk was Stuart. As we know, Stuart felt that he was undergoing sero-conversion and, as such, sought out an interaction with a HCP in order to have a rapid HIV test taken, to confirm or deny his fears. Stuart had been a regular attendee to this clinic, and the previous GUM facility, often presenting with such concerns. Thus, the reassurances he felt in meeting with the HCP were not long-lived. However, it did make a difference, if temporarily:

Stuart: 'They do a really good job, erm, and they've always been supportive and understanding as well I mean when they've got a patient like me who makes things up and think they've got all different kinds of things. Erm, and I'm glad XXXX were the way he was today saying 'look, we've been here before'.

S: 'How did that...?'

Stuart:.. 'that's what I need... Yeah, they're really, really good'.

S: 'So, when you say they're supportive and understanding how's that coming across to you?'

Stuart: 'Just that they know what they're doing and you know, obviously, it reassures me (*uh-huh*), erm, it's probably not as bad as I think it is (*uh-huh*)'.

The reassurances experienced by Garry and Stuart following their time with the HCP were instrumental in helping both of these attendees reconsider their risk status by the time that they left the facility. Of course, and as we have seen with Stuart's story, these reassurances were not permanent, however, it is clear that the interaction with the HCP served to alleviate

the fears of these two attendees. In this way, then, the time at the facility can be understood as remedial with regards to their risk perception, as well as an important site for the self-management of their perception of their physical health. Considering this sense of increased ease, having been through the facility, it is also possible to suggest that the practices of confession that both Stuart and Garry underwent in consultation and with the health advisor (in Garry's case) served to be cathartic and somewhat transformative to their emotional state - this linking to Pryce's (2000) observations of the role of the GUM clinic.

8.2.2 Fertility control

For women attending the IUC clinic, it was clear that fertility regulation was the desired outcome. Most explicit in this was Ania who, attending the booked appointment clinic to get her Cu-IUD replaced, was clear about the role that the facility played in her life:

‘It’s really important to me, um....because I’m, I’m not interested in having children so having access to family planning, erm, is really important from that aspect.’

For Ania, who thought that the facility was ‘great, absolutely fantastic’, it is clear that being able to attend for ‘family planning’ provided her with the ability to remain child free. Her overwhelmingly positive interpretation of her time at the facility, and the interventions available within, was suggestive of the importance she placed on it as a means to maintain her child-free status. In contrast to Ania, we know that Antonia did hope to become pregnant, but not at this time. Consequently, and like Ania in this respect, Antonia also regarded the opportunity to attend the facility positively, as a place through which she could control her fertility until the time was right for her to conceive:

Antonia said that she wanted to get the IUD/IUS because she forgot things easily and didn’t want to get pregnant again without planning. She has just started to see a new guy who she really likes, and who treats her nicely, and so she wants to ‘do things properly this time round’, having had an abortion following a period of domestic abuse [01-05-2014].

For both Ania and Antonia the clinic provided the opportunity to exercise choice and autonomy in their reproductive decision-making. It was a place (as opposed to their GP surgeries) where they could get their preferred method of contraception fitted and, thus, feel

in control of their fertility. It was this option to choose, coupled with a facility that supported such choices, that Louisa found so profound:

‘I am free in my choices. If I want to use contraception it is not something, um, difficult because in Poland it’s really difficult. There is no free condoms, uh, when you get pregnant there is no abortion, so there is no... it is really a big problem to use emergency contraception pills (*mmm*) because even if some doctor prescribe to you, it is really expensive and some pharmacists don’t sell it – don’t want to sell it – if you will give them prescription “oh, I am Catholic, I will not sell it to you”. So, it is really difficult. But here, here no-one ask you, they just give it to you. So I think I found it really *easy* to decide about your motherhood here’.

Having only recently arrived in Scotland from Poland, and having never previously been to a sexual health facility, Louisa was enthusiastic about the freedom of choice that the clinic represented. This made Louisa want to tell others about the facility, saying:

‘I think that when I will met girls who weren’t here I will advise just to visit, because it is for their health, to visit place like that’.

Being able to choose was viewed as a vital part of Ania’s, Antonia’s and Louisa’s lives and, consequently, the clinic was regarded as a place of significance – where they could exercise their autonomy in terms of their reproductive decision-making.

Whether speaking of the changes in their risk perception – a recalibration thereof – or a new found hope or the desirability of a corporeal control through the introduction or re-introduction of IUC, participants’ accounts were about change, transformation and the meaning in their lives thereof. In this way, I agree with Teather (1999: 14) who says ‘what we are looking at... where rites of passage are concerned is, for the contemporary citizen in a wealthy post-modern society, a process of personal transformation’. Crucially, however, it is this personal transformation that also has – in a classical, structuralist understanding of ‘rites of passage’ – a social function. By subjecting themselves to the clinic and procedures for diagnosis, treatment and/or control undergone, these individuals are returned to society as less of a threat to themselves and others. As Long et al (2008: 73) note, ‘hospitals are ultimately liminal spaces, where people are removed from their day to day lives, taken into a betwixt and between space of being diagnosed, treated, operated upon, medicated, cleansed etc.’ before being returned to function in society.

8.2.3 Cause for hope: Possibilities for a new future

While some participants' accounts pointed to a shift in their risk perception as a result of having attended the facility – specifically due to their interaction with HCPs – others saw their time at the facility as contributing to a new found hope in the future.

As we know, Maddie came to the clinic looking for a specific intervention that might help alleviate the physical pain she was in due to her menstrual bleeding. Reflecting on her experience in the consultation room and what transpired, Maddie spoke in terms of hope:

‘Hopefully it means an improvement in my symptoms (uh-huh), and improvement in...er...I’m not stupid enough to think it’s going to mean I’m not going to be exhausted and not feel under the weather, but, I think, it feels like I’ve made a, made a decision to change something, which is quite good – to take control over it a little bit. So hopefully that will mean that something will improve from it’.

Maddie’s exhaustion and general feeling of exasperation at her situation - ‘I got to a point where I couldn’t go on with what was happening with my periods or whatever so I had to do something and I’ve done it’ - resulted in her making a decision, taking control to get the situation addressed. Having attended the facility, she suggested things might get better. There was hope that her pain might diminish. Furthermore, and looking beyond herself, Maddie also indicated a hope that the upheaval she felt her condition had brought upon family life might also be redressed:

‘It’s impacting on our family life and you know me being tired all the time, um, impacting on our life – me bleeding all the time and not being able to have sex – is pretty crap. So, *hopefully*. Time will tell, though, as they say’.

Unlike Maddie, who came to the clinic knowing the outcome that she wished for (and the potential significance thereof on her future quality of life), Lucille found unanticipated hope arising from her visit to the clinic. The health practitioner who saw Lucille for her IUS fitting noticed that she had fibroids and, consequently, initiated a conversation about their management which led to Lucille being referred to an expert who might be able to help. This outcome was not something that Lucille had expected, indeed she had even found the conversation a little ‘awkward’ as it was conducted while she was lying back, ‘knickers off, legs in stirrups’. And yet, as the following excerpt from our interview demonstrates, it was an outcome that Lucille regarded in a positive light:

‘I guess just that you take things for granted on a day to day basis, you just don’t think about it and then you go along to an appointment and there it is in front of you this issue that you’ve gotta sort out (ummm). You can just go weeks and months and years kind of not really thinking about your body I suppose (yep). You know, you just get up in the morning, you go to work and you get in the shower and da, da, da, you know, everything’s always superficial and then they start putting ultrasounds in and I mean that’s my uterus on the screen, you know? You just don’t think about it, *ever*’.

The story of Lucille’s fibroids was that they were diagnosed years prior to my meeting her at the clinic, in an encounter that she found particularly upsetting – ‘they thought it was something really serious – they thought I had a tumour. My husband was with me and I’ll *never* forget his face, it was awful’. Over the years, however, Lucille’s conscious awareness of her fibroids had subsided, as they receded ‘beneath the reach of [her] perception, awareness and control’ (Leder 1990: 54). Lucille’s story is one of contradiction rather than clear distinction between Leder’s concepts, for while saying that she did not think of them, she also said in the same breath, ‘I’ve kind of always felt *slightly* unnerved by the fibroids’. In this way, then, the ‘dys-appearance’ Lucille experience as a result of the ultrasound perhaps functioned to return to memory her fibroids, rather than appear something that, up until that point, she had not known of. With this knowledge, and the encouragement of the practitioner to take up a referral to a specialist, Lucille reflected on how she felt, saying:

L: ‘Good. I know a letter will come in the post with, you know, the referral and yeah, I’m now sure that the wheels are in motion and I do feel like it’s kind of happened for a reason. So yeah, I feel calmer about it all. Hopefully it will mean that there is something that can be done so yeah, it’s good!’

Lucille notes how she feels like it had ‘happened for a reason’ – there is something positive to come from the visit in that her fibroids might be treated successfully, thus removing her aforementioned sense of unease around their (absent) presence.

When it comes to the significance of their time at the facility, we see that Maddie and Lucille both referred to finding hope for the future. In this sense, attending was linked to a significance, be it a lessening of pain (Maddie), or the alleviation of anxiety (Lucille) in moving forward in their lives. The following section will reflect on attendees’ understandings of the clinic itself, rather than the results of their visit.

8.3 Part two: Understandings of the clinic

Given that the foundational concern of this research project was to investigate stakeholder experiences of a fully ISRH facility, I now reflect on participant interpretations of the clinic's remit which might be understood as mediated and informed by the experiences of entering and moving through the facility. To uncover participant understanding of the clinic, I did not disclose the integrated status of the facility. Instead, I listened to attendees' language when speaking about the facility and then asked them about their understanding of the facility during the interview. Over the course of informal interactions, while waiting for the consultation, I had become aware of the variety of descriptors used by participants to refer to the facility, for example the 'GUM clinic' (Danny, Penny, Jimmy); 'STI clinic' (Joe, Samuel, Libby, Harriet); 'sexual health clinic' (Harish, Poppy); 'contraceptive clinic' (Roz); 'family planning' (Georgia); 'emergency contraceptive clinic' (Rosa) and; 'well-woman service' (Antonia). When asking participants to speak more about their perception of the clinic, in an attempt to better understand their labelling of place, it became apparent that all but one of them spoke of the facility using the language of the 'stand-alone' clinic. Only Pippa, attending the facility for her implant to be switched out, hinted at an understanding of the facility as integrated:

'I've only ever used it for contraception – I've never needed to use it for anything else – erm, but at the same time I know that the..I think they were more separate previously'.

What made participants perceive the facility in the way that they did, and to what effect on their experience, will be discussed here.

8.3.1 Construction of place: A reflection of need?

All participants attending the 'walk-in' regarded the facility as a testing service. For all but two of these participants, this construction of place can be seen as a direct reflection of their presenting need. Louisa, Danny, Jimmy, Libby, Penny and Heli attended on account of being symptomatic. Roisin, Holly and Poppy attended for NTT. Garry went in order to secure PEP, Stuart on account of HIV anxieties, Samuel for pre-emptive screening for BBV, and Harish and Joe sought general check-up following 'high risk' sexual encounters. Consequently, fourteen of the sixteen 'walk-in' participants with whom I spent time demonstrated an

individually mediated congruence between their need and perception of the clinic. Harriet and Maddie, despite attending the clinic for IUC, both regarded the facility as a testing service, and saw their own treatment as peripheral to the facility's purpose, perhaps influenced in this opinion by the fact that they both came through the 'walk-in' route. In addition to the 'walk-in' participants, a number of booked appointment holders also viewed the facility as a sexual health service. In this way, these individuals – along with Harriet and Maddie – regarded the facility as somewhat different to their needs. Lucille presented an example of this when she noted:

'I realised, kind of unexpectedly, that it's a sexual health clinic'.

Lucille, who had attended the previous stand-alone FP facility, attended the new facility having learned of the move from the former site. ('I phoned them to make an appointment and they said we're not actually here anymore, we're over at [the integrated sexual health] centre'). Lucille's recollection of the message coupled with her use of the word 'unexpectedly' when referring to the clinic as a sexual health facility, suggests a degree of surprise. She was expecting the new facility to be like the former, and yet it was not. This represents a discontinuation of place for Lucille, like some others, an experience discussed further in the next section.

8.3.2 Continuation (or discontinuation) of place

For those participants who had been to the 'stand-alone' services prior to attending the new integrated facility, the issue of continuation, or discontinuation, of place came up in their reflections on the facility. For some, such as Stuart, perceiving the facility as a place for testing was to view it as familiar and appropriate for his needs. When I asked Stuart to describe the facility to me, he responded as follows:

'Well yeah, it's sexual health testing basically. I think sexual health testing – I don't think there's anything else they do'.

'Sexual health testing'. A place for testing and diagnosis of infections. This is how Stuart expressed his understanding of the clinic's remit. Why he had this understanding was then elaborated on when he said:

‘I don’t think there’s anything else they do. It’s like when it was at [the previous GUM facility]’

For Stuart, then, there is continuation of place between the previous ‘stand-alone’ service with which he was familiar and the new facility. Perhaps supporting his understanding of the new facility as being, ostensibly, the same, is the continuation he also experienced in practitioners across sites. As Stuart reflected on his consultation experiences:

‘Luckily [the HCP] is.., well, I’ve seen [them] loads of times over the years so like a friendly face sort type of thing’

So, despite the change in location involving a shift in practice (from ‘stand-alone’ to integrated), Stuart regarded the facility as the same, simply moved into a new physical landscape. The people he knew from the previous clinic were present at the new location. In much the same way, Harriet also spoke of the powerful influence of having a familiar, trusted practitioner at the new facility, not least because of her ‘complex gynaecological issues’:

‘[They are] just really holistic and care about *me*. [They] go above and beyond to look after me’.

Unfortunately for Harriet, however, this continuation in the relationship was not enough to overcome her sense of frustration that she felt with the new facility:

‘I hate that it’s like a sexual health clinic. I mean, “sexual health” – that’s not why *I* go there! I go there so that I don’t get pregnant, not because I’ve got an STI!’

Harriet felt that she had been ‘forced’ to attend the new facility when the former ‘stand-alone’ service closed down. The result was that she felt a distinct dissonance in terms of her sense of belonging and identification with the new facility.

A few participants did regard the facility as a family planning service (Roz, Georgia, Rosa and Antonia).

‘Not to this building because this clinic was in [the previous location] five years ago when I last came. So because I’ve only used it for one purpose I would say it’s a family planning clinic and I know the doctor who I’ve just seen, from last time it was in the other place’ (Georgia).

When taking all of the participants' interpretations of the facility into account, it is evident that the majority – at times irrespective of their presenting need – regarded it as a type of sexual health clinic. A few called it a variation on 'family planning'. I would argue that only Pippa hinted at an understanding of the facility's broad remit, when she said 'it does all sorts'. *None* used the word 'integrated' when describing how they saw the facility, which is not surprising, perhaps. Indeed, why would this 'industry' word filter through to lay interpretations? As a practitioner suggested:

'I don't know if they would understand the idea of what integration is. It's a bit of a reflection on our status, as professionals, really, more than anything else.'

A reflection of professional status is an important point, for when it comes to the concerns around integration and stakeholder experiences thereof, it must be acknowledged that some of the concerns were linked to professional identity and perhaps, at times, dressed up as concern for attendees. Indeed, the fact that the majority of my participants did not indicate any idea of the facility as integrated does raise the question of the results of previous research into experiences of integration, which predicted attendees would be unduly discomforted by the policy shift. When asked how they felt the service was viewed by attendees, the same practitioner responded:

'So there's the perception that it is to do with STIs rather than necessarily all the other things we do (*yeah*). Amongst patients. So some people do feel...so in terms of integration, I think most people just think it's a sexually transmitted infection place that does other things.'

This perception, then, reflects that participants in my study reported in terms of their interpretation and understanding of place. It was, first and foremost, a sexual health facility. Interpretations of the clinic were subject to change, however, and at times this hinted towards an understanding, albeit not in name, of the clinic as integrated. Indeed, Libby - who we know believed the facility to be an 'STI clinic' - looked back on the facility with new understanding, having attended, as the following excerpt from interview indicates:

S: 'Now, maybe thinking back to what you might've...your preconceptions of what it might've been like and then your experience of what it was like, how does, do they compare?'

Libby: 'Um...well like my preconception was a bit like.. we'll I didn't really want to go but like I felt like I had to go (*umm*). But now that I've been and I realised it's nothing to like.....like you shouldn't really be ashamed of going there like it could be for anything. It doesn't necessarily have to be for like.. something serious, to go there'.

S: 'Ok, yeah. So, um you mean maybe that now you've been there you see it differently....'?

Libby: 'It doesn't have such a stigma that like...if I, like, personally – this might sounds judgemental – but if had heard that someone had gone there you'd probably assume the worst like they've probably got something, some kind of STI or... (*ok*) but then you realise that that's not all they deal with like it could be like, just like psychological stuff or like they deal with all like kinds of things related to it (*yeah*) where before I probably would've judged and been like 'oh, they obviously have something' (*uh-huh*) you know what I mean'?

S: 'So do you think that having been there you might view it in a....'?

Libby: 'Yeah, in a different way (*uh-huh*)'.

Libby was the most explicit in her presentation of a changed view of the facility as a result of attending. Indeed, it did appear to be the case that most attendees considered the facility to be, primarily, a testing facility. The implications of this differed, from attendee to attendee, with some, such as Roisin ('I didn't think further about it'), and Samuel ('I didn't really have any concerns really. I don't find er, this kind of service difficult') through to those who had a more complicated view of things. Lucille, who believed that attending 'any facility, family planning or not, is kind of private and kind of embarrassing for people to know about', thus not positioning a testing service as more problematic necessarily, nevertheless went on to say:

'I know it's wrong and it's being judgemental but being totally honest it feels a bit like you've been up to no good [laughing] (*yeah*) whereas family planning is, aw, family planning – it's all lovely and you're thinking about a family or you're thinking about *not* having a family (*uh-huh*) and you want to do the right thing. It's *family* – it's got the word 'family' in it and its part of a union, you know, rather than a one-off (*oh yeah*)'.

Lucille's comment here resonates with what Scouler et al (2001: 343), in their qualitative study of women's views of GUM services, suggest when they report on the distinction made between GUM and FP services by participants in their research: 'GUM clinics were viewed as

more “dangerous” than family planning services, which had a more benign appeal’. Thinking about why the facility was primarily viewed as a testing service, it is worth - in addition to linking presenting need with perception of place - considering the location of the clinic, as one practitioner noted:

‘I guess it's probably because of the historical location (*oh yeah*). You know, it's very, it's just next to GUM, so it's almost like they've just moved a little’.

This reference to historical location and interpretation of place is insightful and evokes Ingold’s concept of the ‘dwelling place’ – a site within Edinburgh’s urban landscape – an enduring material record of the actions of the past (Ingold 1993: 152). Indeed, with a history of GUM and HIV medicine being located a stone’s throw away from the new facility, while the ‘stand-alone’ FP service had been further afield, it is not surprising that people might view the new facility as a relocation of testing services as opposed to a radical change in service.

8.3.3 The language of place

As described in chapter 8, often attendees in my own research did not appear to perceive the clinic as integrated. Indeed the language attendees used to characterise this place, to refer to Augé’s (1995: 81) terminology, was not the language of policy but, instead, a language of familiarity and, indeed, historically distinct services: ‘GUM clinic’, ‘STI clinic’ and ‘sexual health clinic’; ‘family planning’, ‘contraceptive clinic’, ‘emergency contraceptive clinic’ and ‘well-woman service’. What this finding suggests is a perception of place that is personal, recalling both Gieryn (2002: 44/53) and Collins (2007: 364) (See Chapter 2), who observe that buildings are subject to reconstruction and redefinition at the hands of social actors. For many participants in my study, the clinic was not perceived and understood as integrated, but as a ‘stand-alone’ service, expressed through the language they used to speak of it.

There were instances when attendees did become aware of the clinic’s integrated remit (through, for example, the presence of unanticipated others in the waiting room; the questions they were asked in consultation; or the options for treatment they were provided). Yet this new understanding rarely resulted in negative experiences. To the contrary, for most, integration was positively received. Of course, there were a couple of attendees who expressed clear discomfort at having to attend such a service, most notably Harriet, and yet

even in such circumstances initial reservations and disquiet were still mitigated by the positive aspects of the facility that they went on to experience, namely, it's cleanliness, aesthetic and supportive staff. I admit that this finding was somewhat of a surprise, for, having prepared for fieldwork by reading through existing studies of integrated services which told of attendee views regarding integration, I had simply assumed my own participants would also hold opinions on the matter.

Of course, it could be argued that the language used to refer to place might be the result of a lack of knowledge of the more accurate jargon, 'integrated', and, as such, it would be remiss not to delve more deeply into participants' experiences of the facility and consider these findings in relation to integration. Here I take two of the key concerns that have been reported in existing evaluations of stakeholder views on integration, namely, fears of increased stigma and concerns over the changed social landscape of care that might come with the move to integration, and consider my own findings in relation to these issues. The reason for this is that it might be possible to uncover insights into experiences of integration-in-practice, whether or not they are framed as such by attendees.

8.3.4 A stigmatised, stigmatizing service?

We know from existing studies of integration that the issue of stigma is central to arguments made by proponents and opponents of the policy shift. For those who see integration as a benefit, it is suggested that OSSs might serve to mitigate against the stigma of 'stand-alone' GUM and HIV medicine, for example, by providing women seeking traditional GUM services with 'camouflage' (they might well be assumed to be attending for 'family planning' services) (Dawson et al 2000: 432; Griffiths et al 2008: 5). By the same token, however, critics have noted that such a 'cover' is not extended to men (Dawson et al 2000: 432; Griffiths et al 2008: 5), nor indeed women seeking IUC who, on the contrary, may experience heightened stigma when attending these facilities (Sauer et al 2013). Here I consider these points, in relation to my own findings.

My finding - mentioned above - that often attendees reconstructed the clinic in relation to their own presenting need somewhat complicates the argument that OSSs will provide camouflage to women seeking testing services. Put simply, I suggest that the integrated OSS is reconstructed by individual attendees and as such, the extent to which such a site can

challenge stigma discourse is contingent upon the subjective and social reconstruction of the clinic. Thus, in terms of my own findings, I would argue that because women seeking testing services (Libby, Louisa, Penny, Heli, Poppy and Roisin) regarded the facility as a testing service, rather than integrated - certainly at the point of their initial contact with the facility - felt stigma was still a consideration, albeit one which was experienced to varying extents (as we know, Louisa did not appear to be at all concerned about being known to have attended). So, in such a circumstance that attendees continue to perceive a facility as ‘stand-alone’, despite its integrated remit, I would argue that there is little possibility for integration as a policy shift to change experiences of felt stigma. Further, I would suggest that women’s understanding of the facility as a GUM clinic might well have been influenced not least by the geographical proximity of the new facility to the city’s previous GUM and HIV medicine service. Thus, the possibility of the integrated facility reducing the felt stigma of testing services is somewhat negated. Indeed, as Libby perhaps most explicitly stated (chapter 5), the facility is where ‘bad things’ such as STIs are dealt with.

Taking the issue of stigma, OSSs and the apparent loss of ‘cover’ provided to men, my findings were mixed. In the first instance, Stuart was most explicit in his reporting of feeling self-conscious entering the facility (chapter 5). While not seeing the clinic - in terms of staff members and services available to him - as any different from when he attended the GUM clinic on the other side of the road, Stuart did lament the loss of ambiguity of attendance that came with the move. The previous GUM facility had been housed within a larger healthcare facility and, as such, this ‘stand-alone’ service had, in fact, provided the camouflage that the OSS could not give him. With this said, however, Stuart did not speak in terms of felt stigma. Rather, his language pointed to a sense of momentary embarrassment, and I think this is a crucial difference. Unlike Stuart, the remainder of the men in my research spoke very little about the social stigma associated with attending a known sexual health clinic (for, again, they all viewed the facility as such). When stigma was mentioned, this was refuted. Samuel, Jimmy, Danny and Joe all challenged the suggestion that attending might be somewhat stigmatising. In relation to the suggestion, then, that OSSs might not provide men with ‘cover’, my findings show that this wasn’t a critical concern for the attendees who participated in my research. This may be linked to wider discourses around sexuality and gender norms, whereby women seeking such services are constructed negatively - ‘bad girls’ (Balfe and Brugha 2010), ‘damaged goods’ (Nack 2002; 2000), ‘dirty’, ‘slappers’

(Mulholland and Van Wersch 2007) and the like - whereas men are less likely to be faced with this type of labelling. Indeed, as Nack (2009:2) notes, there is often judgement and blame that comes to women who have infections, with the illness (in her study HPV) considered a 'sign of immorality', low character, bad values and promiscuity.

A final point to make in relation to OSSs and felt stigma is related to women attending for IUC services. It has been suggested that integration, while perhaps mitigating against the stigma associated with GUM services for women seeking testing services, simultaneously contributes to women feeling greater stigma when wishing to attain IUC at such facilities, rather than through 'stand-alone' family planning services (Sauer et al 2013). This, however, is again contingent upon individual perception of place. My findings demonstrate this point further because, in viewing the facility in line with their presenting need - that is 'family planning' - the majority of women seeking IUC in my research did not speak of felt stigma. There were women in my research who gave no indication of their understanding of the facility as integrated, those who expressed an understanding of the clinic as integrated after their visit and, finally, the few who recognised it as, if not integrated, then somewhat different to a 'stand-alone' service.

8.3.5 On the social landscape of an integrated clinic

Integration, by definition and design in the case of the OSS, is characterised by the gathering of heterogeneous attendee population at one facility, 'under one roof' (Gray et al 2009). A result of this is that the once perhaps more homogenous populations of GUM and HIV medicine clinics, on the one hand, and family planning services, on the other, is lost. The social landscape of the integrated clinic is, thus, characterised by diversity. Existing studies of integration have raised a number of key points (mentioned above) which, I believe, can be grouped together under the umbrella concept of the 'social landscape' of place. In chapters 5 and 6 we saw how the process of arrival and admission were supported through the establishment of architectural boundaries that imposed moments of movement and stasis on attendees, moments experienced alongside others. Without rehashing the details of the material presented earlier in the thesis, the findings hinted to an unsurprising variety in opinion, with some views suggestive of a discomfort with the social implications of integration (that is, the mixture of people in the waiting spaces) while others did not appear to

be put off by this. Perhaps the most significant ‘flashpoint’ for discomfort was the foyer, most acutely experienced as off-putting by women attending for IUC (Harriet and Maddie).

Considering my findings in relation to the experience of integration or, put differently, the extent to which integrated service design influenced attendee experiences, I suggest that experiences were complicated, and changeable. While none of my participants spoke in the language of ‘integration’, they, at times, did make reference to the effect of certain results of integration on their experiences (for example, a sense of stigma, or comments as to the social landscape of the clinic). Thus, it seems that, while many did not perceive the clinic as integrated, they nevertheless experienced it, or moments of it, as such.

8.3.6 Reflections on this finding

The finding that attendees rarely related their experiences to the integrated remit of the facility might well be the result of my intentioned decision not to prompt participants explicitly on the integrated remit of the clinic. This, I felt, would allow participants to describe the experiences of the facility in their own terms and, as my findings suggest, other issues arose. Despite, as already mentioned, having prepared for research by familiarizing myself with arguments for and against integration and, consequently, entered the field expecting participants to speak about their opinion of this service delivery shift, it is perhaps not surprising that attendees rarely spoke in these terms. As Stewart (2016: 13) writes of her own experience of researching ‘public involvement’ among young people in a Scottish community, ‘the mismatch between... data and the analytic categories with which I had entered the field’ and what she found to be relevant to her participants was apparent. Stewart says of this discordance:

‘This vision of participation was sharply coloured by a debate which had been generated by academics and policymakers, and bore no relevance to an interviewee sitting worrying about some aspect of their body or mind’ (2016: 13).

Stewart’s reflection is relevant here because, in the case of the participants in my study, it seems that they too were more in tune with their own needs - ‘worrying about some aspect of their body or mind’ - than with the practice of integrated services.

8.4 Part three: Why take part?

In the final section of this chapter – and perhaps a fitting end to the chapters that have represented and discussed participants’ experiences of their time at the facility – I consider why these 29 individuals took part in my research. I had assumed that it might be more challenging to secure participants to the study than it was, assumptions formed, on reflection, as a result of considerations around privacy, stigma, shame and /-or embarrassment related to sexual and or reproductive health that were apparent in existing literature (discussed in Chapter 2). Indeed, as Pippa reflected in the interview following her own participation in my research:

‘Possibly because I dunnae go out and drink and I don’t have a huge circle of friends, erm, then there’s no really anybody that I need to tell (*yeah*). Maybe when I was younger but even then it was never ...Maybe. But it’s not something that you... I don’t know... you might discuss what the person was like that you slept with the night before but you dunnae really discuss your contraception do ya’? I mean, do you tell everyone about it’?

Pippa’s reticence to tell anyone of her attending the clinic is, thus, symbolic of the complexities in our lives - she is secretive, private and yet did not hesitate to speak to me about her experiences. Pippa was not alone in exhibiting this simultaneous desire for secrecy, privacy and selective telling of their trip to the clinic and yet, these concerns were not sufficient to prevent participation in the research. As Peel et al note in a study of why people take part in qualitative research, ‘there might be multiple layers of meaning attributed to the experience by the participants and various motivations for offering to take part in research’ (2006: 1336). In this section I comment on the three more apparent reasons offered by participants in response to the question I usually ended each interview with: ‘can you talk me through your motivation for taking part in this research?’, participants voiced motivations such as an act of kindness, belief in the importance of the research and a desire for company with these categories at times overlapping and multiple.

8.4.1 An act of kindness?

For a number of participants, taking part in the research was expressed in terms of helping me to achieve my goal. In this way, then, I conceive of their participation as an act of kindness, an altruistic act even. For some in this category, taking part was easier to do than it was for

others, as I will now explain. Ania, who we know was attending the facility in order to get her LNG-IUS changed, was very relaxed about sharing her experience with me, a stranger, saying:

‘I kind of thought, oh, this is something that I wonder how many people will actually say yes to because of the subject matter involved and because of my sporting background as I mentioned earlier and because of my background as a physiotherapist and taking clothes off to practice techniques on each other I’m not fussy about kind of getting undressed in front of people or talking about these kind of things so I thought oh right ok I wonder how many other people will be willing to take part in this and I don’t have a problem taking part – yes, I’ll fill in the form and take part, that’s not a problem’.

Ania’s account demonstrates her biographically-informed reasons for not being ‘fussy’ about her body, while also indicating a care for my success in the research endeavour. Another participant who framed their motivation for taking part as wanting to ‘help out’ was Roz, who also attended the IUC clinic. On maternity leave and having ‘time on my hands’, Roz felt no concern in taking part. As she noted:

‘Well, I was going to have to answer questions regardless, so what did it matter to answer a few more of yours’?

This perception of the harmless and innocuous nature of qualitative research participation (Peel et al 2006: 1343) expressed by Ania and Roz was also suggested by those attending the ‘walk-in’, namely, Jimmy, Libby and Harish. Jimmy, who had come to the clinic with symptoms of Chlamydia infection, said:

‘It didn’t make a difference to me. I was going to have to tell the nurse, so it didn’t matter to me that you were there too’.

Here, Jimmy’s narrative suggests that he considered my presence in the clinical consultation to be benign – a harmless witness to his intimate consultation. Given Jimmy’s presentation of himself as being without shame or embarrassment at attending the facility, his willingness to take part is not as surprising as with others, like Libby. Libby’s willingness to take part in my research was at odds with her concerns over privacy. As we know, Libby had not told any of her friends or social network that she was attending the facility. She was embarrassed by

having to go, and as a result, kept her visit private. Despite this, she took part in my research, saying:

‘I just thought that if I was in your position I’d need people to help me. Like I will be in a couple of years, so I just thought why not? It makes no difference to like my life, like maybe an extra half an hour’.

When I followed up with Libby about this willingness to overcome a taboo for the sake of something she viewed as important, she said:

‘I suppose. But then I don’t know you’.

The assertion, from participants mentioned above, that taking part was motivated by a desire to help me – a stranger – succeed in my research endeavour is flattering, and indeed it is easy to take this explanation at face value. Yet, I would suggest, in keeping with aforementioned Peel et al, that reasons for taking part will almost certainly be complex, multiple and, ultimately, only partially apparent to me.

8.4.2 Belief in the importance of research

In addition to those who suggested that their act of kindness was intended to help me personally in succeeding in my research, others linked their willingness to take part to a general belief in the value of research. As Gem noted, ‘sexual and reproductive health, well, it’s just quite an important issue’. Most explicit in this was Georgia, who said:

‘I just thought, well, if it’s any kind of research then that can only be a good thing. So, I don’t have anything to hide and I don’t have a problem taking part and just giving a bit of time, you know, for whatever reason’.

Georgia’s faith in research appears absolute - ‘if it’s any kind of research then that can only be a good thing’ - while also linking back to the idea of harmless participation. Clearly for Georgia, there was little perceived problem in taking part, hence her cooperation. What makes her *ongoing* participation – meaning, her continuation to the interview stage – noteworthy is that she found the IUC fitting extremely painful, and I had anticipated that she would not feel well enough to continue. Addressing this concern in interview, Georgia said:

‘Yeah, it was painful, really painful. But then once it was done, it was done, so yeah, that’s why I’m doing this’.

Rosa also framed her participation as being linked to a desire to contribute, saying:

‘If it helps this service or practice or whatever it’s for then, and it’s not too much of someone’s time then why not? You know? I’m a science teacher so I teach reproduction so I got over that kind of talking about it ‘cause when you’ve got you know kids in front of you and you’ve got to talk about all these body parts and things, you know, it’s you soon lose your um, it’s not a subject that I would get embarrassed or stressed about talking about (*uh-huh*)’.

For Rosa, it is clear that what I was asking of her was not ‘too much’, and coupled with her own sense that taking part was important, to help, then there was little in the way of disincentive for her to participate. Lucille also appeared to value the importance of research in the medical field and, wishing to take part, she spoke of what she understood as being my distance from the topic under examination as particularly important, saying:

‘I’ve always, um, I’ve always supported – especially in the medical field – um, the idea that sometimes you’ve got to have someone in the room who is not the highly qualified, highly experienced professional but who is just someone in there learning and I know that’s not exactly what this situation is but you’re, you know I think you’re still trying to see things that they might not see and give them feedback and yeah, that *has* to benefit someone like me in the end (*uh-huh*), um, so..’

Here Lucille expresses a belief in the beneficial outcomes of research. She continued by talking about how the recruitment process encouraged her participation, saying:

‘And I just thought that the information you sent me in the post was very informative – it was really clear what you were trying to do – and it was also really non-intrusive. I knew that I could just throw it in the bin and there’d be no follow up ‘did you get my...?’ No, it would be totally my decision, so, um, I was happy. And then the actual experience, yeah, it was great. I really liked that you texted me maybe a week or two weeks ago (*yeah, yeah*) and then said that you’d text me again the day before. But again it was just a really casual, non-invasive text, um, and it was easy to know what you were gonna look like and that I’d find you so no I just thought the whole thing went really well’.

8.4.3 To not be alone

A final reason that participants took part was linked to a desire not to be alone or, as I put it, the comfort of being with a stranger as they waited and experienced their time at the facility. I start with Danny, who recounted:

‘Well, today, because I was sitting with you I felt really comfortable. It felt ok. Other times, you feel a little bit tense because you are aware that other people are looking at you’.

Danny, who we know had a complex relationship with the facility, which has been conveyed throughout the thesis, appeared at times to be confident. Indeed, when I asked him directly why he had taken part in my research, he spoke in terms of wanting to help. But he also brought up his own desire for company:

‘So, it’s like, I know I could help, because I know this clinic - I’ve been here a lot. But, like I said, it’s awkward sometimes, and it’s nice to have a distraction I suppose’.

Similarly to Danny, Stuart also suggested that having me with him ‘helped with the nerves’. So, despite both of these attendees knowing the facility well, on account of their regular attendance and engagement with the service, they nevertheless felt a benefit from not being there alone, of having company when they felt somewhat nervous, or intimidated. This sentiment was echoed in others, too, for example, Joe who said:

‘I think if someone’s there it helps to break the tension, like if someone chats to you it makes it better’.

So, for attendees like Danny, Stuart and Joe, as well as Jules and Samuel, it was clear that taking part was regarded as providing a comfort of sorts, be it a ‘distraction’ from what was about to happen, or company in an awkward social setting, or indeed a way to ‘pass the time’ (Samuel). These reasons, when taken together, point to a possible benefit of having a ‘buddy’ while waiting, something which I did not anticipate at all a being a motivator for participation in my research.

In sum, participants provided me with three narratives when it came to their motivations for taking part, two of which were vaguely altruistic. Of course, it is not appropriate to dismiss these narratives as dishonest, yet, it might also be worth considering the fact that, at least for

some of these attendees, participation might have been linked to their anxieties (as discussed in Chapter 5 and 6) about attending the service. Taking this view, it might not have only been Danny and Stuart who were motivated to take part in my research so as not to be alone, or to be provided with a form of ‘camouflage’ in the face of intimidating ‘others’ in the waiting spaces of the facility.

8.5 Conclusion

This chapter has discussed participants’ reflections of their time at the facility, focusing on the transformations that they underwent by virtue of attending, the extent to which participants indicated an understanding of the facility as integrated, and, their motivations for taking part in the study. When it came to experiences of an integrated facility, the chapter has demonstrated that attendees’ understanding was complicated, at times contingent upon past experiences of ‘stand-alone’ services, and rarely understood as integrated. This perception was, for some, changed on account of their time at the facility. Finally, I considered some of the reasons that attendees took part in the research, noting how the wish to not be alone was particularly unexpected. As I now move on to the Discussion, I leave participants’ accounts and my field-notes behind, in order to reflect on my findings in relation to existing literatures.

9. Discussion

9.1 Introduction

This thesis started with the question of how attendees experienced their visit to a fully integrated sexual and reproductive health care facility, a question informed by the recent move to integrated services and associated uncertainties regarding stakeholder experiences, outlined in Chapter 1. My findings followed attendees from their arrival at the facility (Chapter 5) through to being admitted (Chapter 6), undergoing the consultation (Chapter 7) and after leaving the facility (Chapter 8). These chapters discussed attendees' anticipatory experiences of the clinic, and found they were based on socially mediated pre-conceptions, or prior experiences, of the facility. Motivations for attending hinged upon risk-perception, for self and/or others. Upon arrival at the facility, experiences were commonly influenced by the affective landscapes in each of the sorting spaces where attendees were placed. As attendees moved through the sorting spaces, from larger heterogeneous groups to smaller, more homogenous groups (NTT, 'general clinic', IUC), they often reported feeling more relaxed and secure in their sense of belonging, this in terms of, both, feeling the right to be at the facility but also with regards a sense of identity with the 'others' around them. During consultations, attendees were noticeably cooperative and compliant, even in the face of mandatory questions and intimate examinations which many, having left the facility, described as having been uncomfortable. Throughout their time at the clinic, many of the attendees did not demonstrate an explicit knowledge of the facility's integrated status, instead referring to it using stand-alone terminology, such as 'family planning' or 'GUM clinic', based on their presenting need.

Taking these observations above and considering them analytically, the discussion will explore what I see as being the three major findings of my research, reflecting on their importance within the context of existing literatures on 'therapeutic landscapes', doctor-patient interactions in the context of sexual health, and integration. I start by reflecting on attendees' experiences of the clinic in relation to the concept of 'therapeutic landscapes'. This finding is considered in relation to existing applications of 'therapeutic landscapes' which, to date, have rarely focused on transient spaces of healthcare delivery and certainly not integrated sexual health facilities. Following this, I consider possible interpretations of the

cooperative demeanour presented by attendees during their time at the clinic and, most discernibly, during consultation. In this regard, I will offer two, interlinked, explanations that relate to, both, particularities of the facility itself alongside wider social norms and expectations. Finally, I discuss my finding that attendees did not experience the clinic as integrated, instead commonly reinterpreting and reconstructing the facility in line with their presenting need: a ‘GUM clinic’, or a ‘family planning’ service. In this way, then, place is not immutable and, in the case of integration, this finding complicates some of the assumptions that have been made regarding how integration as a policy shift will affect attendees. Following discussion of my key findings, I then consider the implications of these findings and reflect on the study’s strengths and limitations.

9.2 Experiencing the clinic: On the ‘therapeutic landscape’.

Attendees’ experiences of their time at the clinic were clearly influenced by the affective propensity of the ‘therapeutic landscapes’ (Gesler 1992). As a reminder, physical landscapes are the material ‘bricks and mortar’, architectural features or, in the case of the natural world, the landscape itself. The social landscape is comprised of power dynamics and interactions and, finally, symbolic landscapes include the artefacts, objects, language and meaning that comprise place (Chapter 2). ‘Therapeutic landscapes’ are to be considered as the confluence of these individual affective influences. Attendees’ responses to these affective plains of influence were predictably complex, experiencing the landscapes sharply (both positively and negatively). While inpatient facilities feature commonly in the application of ‘therapeutic landscapes’, as addressed in Chapter 2, transient spaces of healthcare provision, visited on rare occasion and characterised by high mobility, have been neglected. My findings help to address this gap by demonstrating how, despite spending little time in this facility, the physical, social and symbolic landscapes were nevertheless experienced as significant. We saw, for example, in Chapter 5, how many of the attendees were surprised by the foyer – its lack of space, cramped conditions and the symbolic weight of the laminate numbered card (this last point, particularly, in reference to Maddie’s experiences). The conditions in the foyer (created, in part, by the confluence of affective landscapes) influenced attendees’ experiences as they waited. These initial experiences, I would argue, further served as a benchmark for attendees’ later experiences of the ‘sorting spaces’ of the facility, as they made their way through to the main waiting room, atrium and hubs beyond. Along this journey, we

saw how the main waiting room's aesthetic was regarded positively by most and, in the case of Jules, attributed with therapeutic properties (Chapter 6). The atrium was experienced as a space for momentary escape, as attendees' spoke of how it reminded them of other places, such as libraries, or museums.

The finding that different spaces within the facility were experienced positively or less so, and for a variety of reasons, suggests that, in settings where there is little opportunity for a therapeutic community to grow (referring to a therapeutic social landscape), it falls to the physical landscape to be the primary means through which, and by which, designers foster positive place experiences. There is research to suggest that, in 'therapeutic landscapes', the physical landscape matters far less than the creation of a therapeutic social landscape. For example, in her ethnographic study of the dissident, anti-psychiatric spaces that survivors of mental health institutions appropriate for their grassroots self-help meetings, Laws (2009: 1828-1829) astutely points out that spaces do not need to be aesthetically pleasing to be experienced as therapeutic. Indeed, favoured spaces of this group included the bathroom of locked wards, bars, fast-food joints and parks known for vagrants and dogging (Laws 2009: 1829). Laws' contribution to 'therapeutic landscapes' is an important one, not least because it assigns power to would-be patients of psychiatric institutions to decide for themselves what they denote as therapeutic, rather than relying upon 'top-down' decisions as such. Wood et al (2013) in their study of the 'spaces for smoking' in a psychiatric hospital also speak to this issue of fostering spaces of resistance and therapeutic social landscapes, in this instance still within the institution. As with Laws, there is an emphasis on the import of the social and symbolic landscapes over the physical, the latter being most focused on in hospital design (Wood et al 2013: 105). While I am sympathetic to Laws' and Wood et al's summary and do not wish to promote the importance of aesthetically pleasing environments over and above the importance of supportive and therapeutic social and symbolic landscapes, there is a fundamental difference between these field-sites and my own: inpatient in contrast to highly transient outpatient spaces. I argue that in a context such as my field-site, which is characterised by social stigma and associated felt stigma of attending, where attendance is often experienced self-consciously, coupled with highly transient and rare attendance, there is perhaps greater need to create a therapeutic aesthetic, for it is not an environment wherein people get to know one another. This was an intention in the design of the facility, as mentioned in Chapter 6, yet perhaps more could be done.

While it is the combination of social, symbolic and physical landscapes which can work together to create therapeutic spaces, as discussed in Chapter 2, it is also the case that individual affective plains (so, the physical, social and symbolic landscapes taken individually) can also counteract, or undermine, the others. Having discussed my findings in relation to the importance of the physical landscape in the context of my field-site as an example of a highly transient space of healthcare delivery, I now turn to consider the ways in which the positives of the physical landscape were at times challenged by the social and symbolic landscapes that attendees encountered as they journeyed through the facility.

9.2.1 Tension between landscapes

While participants spoke of the positive influence of the physical landscape on their experience of the clinic, for example, the light and bright main waiting room and atrium that worked to challenge preconceptions of ‘grotty’ sexual health facilities, their narratives reflected creeping negative elements of the social and symbolic landscapes on their experiences as they waited. What I mean by this is that the demands of creating a functioning facility which met the needs of the facility’s organisational logic were experienced as being at odds with the therapeutic intentions, and perceived benefits, of the physical landscape.

All of us will have spent time in waiting rooms, either seeking help for ourselves or accompanying friends, family members or partners as they do so. These are familiar spaces with recognisable functions which, almost certainly, include processes of registration, organisational sorting and categorising of attendees. At the field-site in this research, participants were subjected to processes of dividing and labelled according to the social order of the clinic, prior to being permitted any further. This entailed processes of registration and/or triage and subsequent allocation to smaller waiting spaces. While the physical landscape of the main waiting room was received positively, it was this process of waiting to be admitted to the clinic that attendees often found difficult. Waiting to be sorted according to the organisational logic, amongst a heterogeneous and often busy attendee population, made for an uncomfortable social landscape. Put in terms of ‘therapeutic landscapes’, the social landscape of the main waiting room challenged the positive impact of the physical landscape. We know from chapter 6 that attendees often recalled their time in this space in particular as anxious, awkward and confusing. They would keep their heads down, seeking to remain invisible to one another, often using their mobile phones as ‘props’ in this game. Thus, it

could be argued that the main waiting room in particular presents an example of spaces that can be, rather paradoxically, both therapeutic and un-therapeutic (Wakefield & McMullan 2005, Plane & Klodawsky 2013).

In addition to the potentially negative influence of the social landscape of the main waiting room, the liminality of the space also appeared to work to corrode the positive influence of the space's appearance. Designed as a boundary space or a space that, as Tanner (2002:116) notes, 'people pass through, en-route to somewhere else, a temporary stop rather than a destination', it could be argued that the waiting room is a site par excellence for being not yet arrived. In this space, attendees experienced themselves as being more inside than in the foyer and certainly no longer outside, yet nevertheless still in the arriving part of their journey. This transitional, and liminal, condition was characterised most notably by the symbolic weight of the laminate numbered triage cards, which reinforced attendees' uncertainty over whether they belonged, due to the access requirements outlined on the card and the dehumanizing effect of the object, as was discussed in Chapters 5 and 6. This, most explicitly, with regards Maddie's experiences, who experienced the moment of having to take the card as a shock, to the extent that she left the clinic to wait elsewhere, in tears. Libby, who did not find the symbolism of the laminate card so shocking was, nevertheless, unsettled by the language used on it – for the language introduced the question of whether she would be viewed as legitimate to the facility. Libby's uncertainty remained until she was provided with a space on the general clinic care pathway.

In each sorting space of the facility, the physical landscape was a stage and an aid to social action, some of which counteracted the positive affect of the facility's aesthetic. The symbolic landscape of the foyer - the lack of chairs, the numbered card - reinforced the liminal function of the space, contributing to attendees' anxiety around their acceptability to the facility. The waiting room, which attendees expressed as being better appointed aesthetically, nevertheless continued to reinforce the sense of uncertainty of belonging, both to the institution ('will I be admitted?') and to the population with whom participants sat ('are they here for the same things as me?'). Crossing into the atrium symbolised arrival and allowed attendees to focus on the purpose of their visit, reinforced by the segregated hubs, which assigned individuals a purpose and a reason for being at the facility. As described in Chapter 5 and Chapter 6, most attendees' unease about the facility was focused on the liminal spaces, where the facility's

sorting functions took precedence. Here the needs of the organisational logic appeared to be experienced as at odds with the therapeutic intentions of the physical landscape, a result of the creeping negative impact of the combination of the physical, social and symbolic, as they waited within these spaces. In this way, then, while I suggest that the design of therapeutic physical landscapes might be even more pressing in facilities such as my field-site, it is also the case that in such design there needs to be consideration of the social action that will go on within and how this action might influence experiences.

Looking at attendee experiences through the lens of therapeutic landscapes has brought to the fore this tension between the therapeutic intentions of design and the organisational logic of the clinic. The next section will explore how the disciplinary role of the affective landscapes appeared to shape attendees' demeanour during their time at the facility, most notably during consultations.

9.3 On being grateful: Interrogating participants' demeanour.

Each of the attendees in my research can be seen as an 'active patient' (Armstrong, 1993) who engaged deliberately with healthcare services. However, my findings in Chapters 6 and 7 suggest this assertiveness was commonly replaced with a cooperative demeanour when interacting with staff. In almost all instances, attendees appeared to assume a submissive, cooperative roles in their interactions with members of staff at the facility. Their behaviour is not necessarily unusual, despite the advance of the 'assertive patient as health consumer' (Nettleton 2013: 123). In this section, I consider what lies behind the amenable, cooperative demeanour of attendees. I argue that this can be explored in three ways. First, I discuss the possible impact of the facility's disciplinary architecture and organisational practices, which appear to transform attendees into patients. Second, I argue that the facility's therapeutic aesthetic might be implicated in the power relations which foster docile patients. Finally, I look at how broader social narratives around stigma and the responsible self-permeate the clinic, producing patients who are invested in their own treatment.

9.3.1 'Partitioning' and affective, disciplinary architecture

It could be argued that the facility's sorting spaces (Chapter 6) are contemporary examples of Foucault's (1997: 143) concept of 'partitioning', one technique for the expression of

disciplinary power in architecture, whereby ‘each individual has his [sic] own place; and each place its individual’. As described in chapter 6, attendees underwent a process of sorting into groups depending on their presenting needs, and were then physically sorted into hubs which defined their attendee ‘groups’, such as IUC, NTT and ‘general clinic’. This architectural ‘partitioning’ evokes what Foucault (1977: 172) describes as the power of architecture ‘to permit an internal, articulated and detailed control – to render visible those who are inside it... an architecture that would operate to transform individuals... to make it possible to know them, to alter them’. In the case of the clinic this ‘partitioning’ is achieved through the combination of architectural spaces with staff mediated organisational processes. I argue that this sorting process acted on attendees, establishing them as ‘patients’ and recalling all the social norms that this role implies.

As attendees waited in and passed through the facility’s sorting spaces, they often described feeling more comfortable in their surroundings and in terms of the anxiety they felt about their presenting need. In Chapter 5, my findings show how attendees felt the most uncertainty in the foyer, waiting amongst a heterogeneous population, uncertain of whether they would be admitted. It was not until they had been processed and assigned to a care pathway that the ambiguity they felt over their liminal status was resolved. At this point, they were ‘patients’. They understood their place within the institution, a place anchored in pre-existing understandings of their role as patients. In this way, the facility’s disciplinary architecture and organisational logic enacted ‘partitioning’, making the attendees knowable to staff and to themselves.

In my study, I observed most attendees adopt a demeanour of active compliance. This is a variation on the more passive role of the patient in the ‘paternalistic’ model described by Parsons (1951). This variation is in line with Williams’ (2005: 134) corrective attempt to reframe so-called ‘passivity’ in the doctor-patient interaction, highlighting that ‘acceptance of treatment itself... is one type of *active* participation’. In my observations, attendees appeared to deliberately adopt a compliant demeanour, sometimes actively resisting practitioner attempts to deliver a more collaborative consultation. This contrasts with trends towards other models of doctor-patient interaction (Chapter 2). Why was this so? I argue that the attendees in my study perceived themselves in acute need (Chapter 5 and Chapter 7), whether related to sexually transmitted infection or fertility control. In such acute circumstances, the attendees

appeared eager to avail themselves of technical expertise – to ‘get in and get out’ as quickly as possible. It could be argued that this preference for practitioner expertise is linked to notions of the responsible self, which will be discussed after considering the disciplinary role of aesthetics.

9.3.2 Aesthetics’ disciplinary role

As my discussion of therapeutic landscapes showed, the ‘aestheticisation’ (Collins 2007: 351) trend in healthcare design and architecture to manage and mitigate the stress that people experience in hospitals and clinics had a broadly positive effect at the facility where my study was based (Chapters 5 and 6). Pertinent examples of this in my findings include the aforementioned positive surprise of a facility that did not appear ‘grotty’, thus challenging stereotypical expectations held by many attendees, and the atrium as a space of momentary escape. However, the aesthetics of the facility might also be considered as playing a disciplinary role in the clinic. In their study of ‘therapeutic aesthetics of medical spaces’, Evans et al (2009: 718) note that the use of artwork depicting therapeutic places, such as natural scenes, aids in the creation of docile patients who will be amenable during consultation. Thus, ‘artwork functions as a tool for a power-laden process’ (Evans et al 2009: 718) in the clinic. I argue that my own field-site’s use of colour, lights and the hanging of artworks in various spaces is informed by an understanding of the benefits for the organisation, as well as the individual, of fostering calm among attendees. This can be seen in the experiences of Jules (Chapter 6), who noted how the aesthetics of the main waiting room helped calm her nerves, and in attendees’ response to the atrium (Chapter 6). Thus, it could be argued that a calming, aesthetically pleasing space may help engender a calmer, even compliant patient³¹.

Now I turn to discuss attendees’ seeming active compliance in the consultation through a consideration of biopolitical notions of the responsible self.

³¹ Work from environmental psychology has, arguably, been highly influential in this move to bring nature inside healthcare facilities, as a result of findings which point to stress alleviation (Saffarinia et al 2012; Rappe 2005; Ulrich 1979) and, at times, better tolerance of pain and speedier recovery (Parks et al 2004) when such facilities are designed with the natural world in mind. Indeed, in Saffarinia et al’s (2012: 690) study of ‘the effect of environmental design by natural elements on decreasing a waiting patient’s anxiety, blood pressure and pulse rate’ they argue that while the waiting room is a site often experienced anxiously, it is nevertheless possible to ‘change this human psychology conception’, through the use of ‘images of the natural environment in waiting rooms’.

9.3.3 The responsible self

I have reflected on the disciplinary influence of the clinic itself. In keeping with the assertion in Chapter 1 that the clinic is not to be regarded as an island, apart from wider society, I now move on to consider the way in which social discourses of stigma around sexual infection and unintended pregnancy appeared to have contributed to attendees' motivations for seeking treatment and their active compliance within the facility. I suggest that these discourses around sexual health and reproductive control are linked to broader values regarding socially responsible self-management. In considering 'what is said and done' (Day 2007:29) during the consultation, it is helpful to look beyond the facility's walls and consider the wider context when interpreting these situated interactions.

Individual sexual health and fertility has been framed as a public health concern, evidenced in many areas, not least the integration of GUM, HIV and FP which, as mentioned in Chapter 1, seeks to improve the efficiency and efficacy of interventions, this in the pursuit of lowering rates of unintended pregnancies, HIV, and STI transmission. Central to these agendas is a focus on the role of individual behaviour in the management of the health of the individual body as well as the social body. My findings in Chapter 5 show many of those presenting for sexual health testing expressed a sense of personal responsibility to control the risk that they presented to others, such as partners, or in some cases as yet unknown others. In this, they expressed an understanding of cultural attitudes which frame STIs as 'morally, socially, environmentally and biologically dangerous or "risky"' (Pryce 2000: 104). In contrast, those who attended the IUC clinic rarely mentioned the public health implications of an unintended pregnancy. Instead, they spoke of their personal desire for a method of contraception which they regarded as being most convenient and unobtrusive for regulating their fertility. Such personal motivations must be understood, however, within the wider social discourse wherein women remain overwhelmingly responsible for their reproductive potential, a discourse which transforms contraceptive responsibility into a narrative of the responsible (female) self. Indeed, as Oudshoorn (*own emphasis* 2004: 353), writing from an STS perspective, notes of what she refers to as 'the gender gap in contraception':

'In the second half of the twentieth century, the idea of woman as the sex responsible for contraception...became the dominant cultural narrative materialized in

contraceptive technologies, in social movements, and the gender identities of women and men’.

Paradoxically, in choosing IUC, which women considered to be the least inconvenient option available, they had to submit to an invasive medical procedure over which they had little control. As Medley-Rath and Simonds (2010: 784) indicate in their discourse analysis of contraceptive advertisement in the United States, ‘the mediation of a healthcare provider (i.e. doctors and pharmacists) in women’s obtaining contraceptives means that the power to prevent pregnancy does not lie with women’, this compared to male-controlled contraceptives (condoms, primarily). I argue that, both, the broader climate of female responsibility for contraception and fertility regulation, coupled with the paradox that ostensibly female-empowering, invisible contraception demands engagement with HCPs, led to what I observed in the IUC attendees in my study: a general, no-fuss eagerness to get on and get done, a willingness to perform the compliant role of a patient, and a preference for clinical expertise to expedite the operation.

For both booked appointment holders and walk-in attendees, it is hard to disentangle the personal motivations from the broader social discourses and norms which may have shaped those motivations. Such is the character of contemporary biopower and the responsible self, in which neoliberal ideals of personal responsibility are adopted and reconstituted as internal desires. Foucault (1978: 39) describes this as, ‘the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives’. Regardless, my research suggests that the responsible self was at play in the doctor-patient interaction, producing attendees who chose to ‘delegate... responsibility to the physician’ (Charles et al 1997: 683). Such active compliance is linked to the specific aforementioned context of the attendees in my study and should not be taken as a broader refutation of efforts to empower patients. Indeed, by choosing active compliance, I argue that these attendees were empowered, even if they chose not to challenge clinical expertise. This links back to findings from Pryce (2000) and Boydell (2010) (Chapter 2), both whom demonstrated how attendees in, either, GUM clinic consultations or when seeking contraceptive services, respectively, spoke of engaging in strategic game with the HCP in order to achieve what they wanted from the consultation.

We see a similarity in a degree of strategizing among attendees in my own research, this understood as being in order to get what was desired from the interaction, for example, in Georgia's account (Chapter 7) of how she endured the pain of her IUC fitting, without complaint, in order to encourage the HCP to continue trying despite the difficult and protracted time attempting to fit the device. Put simply, 'discipline may be welcomed as positively empowering, experienced through discourses of self-improvement that are both internalized and personalised' (Scott 2010: 221). In this way, then, I interpret attendees' behaviour as a considered way to defer to the power of the HCP in order to act 'in their *real* interests' - an exercise in agency (Scott 2010: 221). This agential act must, however, be contextualised within the broader social discourse of the responsible self, which exemplifies the 'biopolitical script of a free society... the "practice of self", or self-governance, facilitated by the discourse of choice' (Takeshita 2012: 29).

Having addressed attendee experiences of the therapeutic landscapes that comprise the clinic, and reflected on their performance of cooperation during their interactions with staff members while at the facility, I now consider the foundational question of the research: attendees' experiences of an integrated facility.

9.4 Perceptions of the clinic: Integrated, or 'stand-alone'?

We know, from the review of existing studies of integration in chapter 2, that there is little consensus as to the impact of integration on stakeholder experiences and preferences. Multiple considerations influence opinion of integrated services, both for attendees and potential attendees, as well as staff members. Existing studies have discussed a number of concerns that influence attendees' preferences for, or rejection of, integrated services over 'stand-alone' options, including the location and accessibility of the clinic (French et al 2006; Griffiths et al 2008; Gray et al 2009), staff attitudes (Hitchings et al 2009; Griffiths et al 2008), interpersonal relationships and the presence of other attendees (Griffiths et al 2008), competency of delivery and confidentiality (Griffiths et al 2008; Hitchings et al 2001) and stigma (Gray et al 2009; Sauer et al 2013). For staff members, expectations that integration will bring with it improved continuity of care and the opportunity for opportunistic testing and infection control have been regarded as positive (Kane and Wellings 1999: 134), while concerns over the logistics of implementation (French et al 2006: 203; Kane and Wellings

1999: 136), loss of distinct cultures of care and associated potential loss of well-defined career progression (Kane and Wellings 1999: 136) have been raised as possible detrimental outcomes to integration. It is within this broader literature that I position my findings.

My findings in this regard emphasise the importance of perception of place on experience. While the facility has been designed with the intention of being integrated, and offers integrated care, as I described in Chapter 8, attendees did not experience it as such. Instead, they reconstructed the clinic as aligned to their presenting need, for example a ‘GUM clinic’ or a ‘family planning’ service. Thus, there is an important distinction to be made between intended and perceived place, an observation made by theorists such as de Certeau, Tuan and Lefebvre (Chapter 2). Buildings cannot simply *be*, they are not immutable. Rather, as architect Ed Hollis (2010) reminds us, they are subject to change with time and in relation to our individual and collective perceptions.

This complicates the picture presented by some of the existing studies on integration, which sought to gauge attendee expectations or reactions to integrated facilities. In many of these studies, participants were made aware of and asked to focus on the integrated nature of the facility, an approach which my research suggests may not capture the actual experience of many attendees. Since many of the studies were billed as evaluations performed by the One-Stop Shop Evaluation team in a short time frame, their approach was understandably constrained. My findings show the differences between measuring attitudes towards policy, which often necessitates narrowing participants’ focus on a single issue, and exploring attendee experiences of place ethnographically. This latter approach allows for the emergence of new and unanticipated insights (Chapter 3) and, as I found over the course of my own research, experience of an integrated facility is formed of far more than integration alone.

9.5 Investing in a therapeutic physical landscape

When considering the implications of my findings for policy and practice, I suggest that the most significant issue is that of the reputation of the integrated facility in terms of how it is viewed by the general public and those attending. Despite the facility’s integrated status and the hope that integration will bring with it a diminishing of the stigma associated with GUM and HIV medicine, this does not seem to be the case. Instead, the clinic was either viewed as a GUM facility or, when it was understood as offering a wider range of services, it was

nevertheless the association with GUM that maintained concerns around stigma among attendees. In a climate where sexual health remains a ‘Cinderella service’³², linked to stigmatising social discourses, the question of how to challenge such influences is a pressing one, not least because stigma serves as a strong deterrent to attending for services. While it might be difficult for a clinic to challenge the stereotypes that result in making sexual health facilities stigmatized and potentially stigmatising places, it is possible to change the impression of the facility among those who do attend. In this regard, and in relation to my findings, I suggest two areas of focus, based on ‘therapeutic landscapes’.

In terms of the physical landscape Gesler (2003: 111-113) notes that ‘therapeutic landscapes’ can be improved by top-down interventions, specifically, through design features that can be evaluated in terms of their effectiveness. My findings lead me to agree with this position, in the context of sexual and reproductive healthcare delivery, arguing that investments made to the aesthetics of the spaces, such as the inclusion of artworks and natural elements such as plants, that comprise the clinic might serve to challenge the status of such services as places for the treatment of social deviance. As Day (2007: 15) points out of the physical landscape of the GUM clinic ‘dismal waiting areas can...make patients feel stigmatized’. Perhaps, then, it is more aesthetically pleasing landscapes that might help to mitigate against negative stereotype of such facilities, as my findings have suggested. Yet, while there has been much interest in improving the physical landscapes of healthcare facilities such as palliative care units, children’s hospitals, hospices and the like, sexual and reproductive healthcare facilities have been overlooked. Perhaps this is because of the relative brevity of time spent within, but this could also be a reflection of wider social opinion of such facilities as not being worthy of such investments. The expectation that sexual health services will be ‘grotty’ is not without cause, yet unlike the complex biographies with which individuals attend services - biographies which certainly influence experience of care (Weston et al 2010: 587) - and which it is difficult for services to anticipate or indeed manage, investing in the ‘therapeutic landscape’ of the facility is a more achievable goal.

³² Sexual health, in particular, has long been a ‘cinderella service’, this brought to the fore with contemporary Tory government cuts to sexual health services in England estimated to reach £40 million, resulting in the closure of long-standing facilities such as the Margaret Pyke Centre in Kings Cross, London (BBC News, 2016; Campbell 2016).

In addition to possible improvements to the physical landscape, it is also worth considering the social and symbolic landscapes that attendees experienced, most notably in the earlier stages of their clinic journey, being in the foyer and the main waiting room. Improvements could, perhaps, be made in terms of the ways in which the organisation outlines appropriate usage of the facility, while striving to maintain a sense of openness and welcome to attendees who might well feel stressed and anxious about their presenting need. For example, the laminate numbered card had a significant (and negative) symbolic weight for some attendees and, perhaps, this system could be reviewed and improved.

9.6 Strengths and limitations

One of the strengths of this research study was the ethnographically-informed methods and their application to exploring attendee experiences of an integrated sexual health centre in real-time. This brought to light nuanced insights, complicating findings from existing studies and demonstrating how attendee experiences are shaped by complex, multi-faceted considerations both inside and outside of the clinic. In addition, my participant recruitment strategy for walk-in attendees to a service widely seen as stigmatised was more successful than anyone anticipated. This could serve as an example to other studies which seek to engage with unscheduled attendees.

When considering the limitations of this research, there are a few points for reflection. In the first instance, I am aware that despite my efforts to make my role a researcher clear to participants, it might well have been the case that they viewed me as an ally of the clinic, if not working directly with the facility then nevertheless associated with it. It was unusual for attendees to complain to me about their time at the facility and, if they were unhappy, statements to this effect would often be followed up with empathetic comments about the extent to which the staff could do better. I do wonder, therefore, whether there was a reticence among attendees to be overtly critical of the facility on account of their possible lack of clarity as to my position. With this said, I also got the impression from some attendees (Chapter 8) that they saw me as a befriender of sorts – supporting them and easing their time at the clinic by virtue of sitting with them as they waited.

A second point is that participants in my research were all attendees to the service and, thus, they came from a portion of society who are actively engaged in managing their sexual and/or

reproductive health. Therefore, the findings are not to be considered as in any way representative. Yet, as discussed in Chapter 3, this was not the intention of the research for reasons linked to the ethnographically-informed design of the study. In terms of future research, however, it might well be interesting to engage with individuals who do not attend this facility (although this would present logistical challenges in terms of accessing such individuals and recruitment) in order to compare the reasons for engaging with, or avoiding, the service.

A further limitation is that I was unable to speak to the architects involved in the re-provisioning of the facility. As mentioned in Chapter 3, this was the result of the architect's own exit from the process prior to the opening of the new facility, and no response from the firm that took over the project nearing its end. In the context of growing interests in the sociology of materialities of healthcare, this lack of representation from the actor involved in designing the affective spaces of the facility results in a gap in insight that would have been informative.

Finally, and by virtue of very focus of the research and the methodological approaches applied to investigating the question of attendee experiences of integration, the research can only speak of the experiences of a small number of individuals accessing services at one facility and at one moment in time. This will, of course, limit the generalisability of findings. Yet, I do not consider this to be a limitation as such, rather a consideration to bear in mind when reflecting on the conclusions I can draw from the research.

9.7 Conclusion

This research suggests that of all the factors which effect attendee experience, the integrated nature of the facility plays only a minor role. At times, it did not appear that the integrated remit was recognised by attendees and, when attendees were aware of the facility's broad services, this was rarely a cause for great concern. Considering we all come to health care facilities with our own biographical history, an individual facility can only do so much to ease the experiences of attendees. As Huby notes, 'people's evaluation of services are grounded in factors outside the service encounters themselves' (1997: 1150) and, as such, it is clear that there are limits to what a service can do to improve everyone's experiences. However, by making interventions that improve the experiences of attendees within the facility, and

counteracting stereotypes about the nature of sexual health, health care professionals can make some small impact on the broader narratives of stigma and responsibility which shape attendees' lives before they arrive.

10. Conclusion

This PhD research was conducted with the aim of gaining insight into the experiences of attendees to a fully integrated sexual and reproductive healthcare facility. While a handful of pre-existing evaluations have sought to assess the acceptability of integrated services among certain patient groups, these investigations were often conducted using quantitative methods and, thus, prescriptive in their questioning of experiences based singularly on integration. An ethnographically-informed study, this research took a different approach, widening the lens of enquiry beyond the narrow scope of integration, and seeking to explore participants' experience of the facility in their own terms. Engaging with 29 attendees at various points in their journey, this research found participants' accounts replete with complex and multiple understandings of the clinic, among which integration proved a minor point. In this conclusion, I summarise what I consider to be the most important and insightful findings of the research, starting with the question of integration itself.

10.1 The issue of integration: Destabilising assumptions

This study found that the integrated status of the facility did not play a significant role in how attendees narrated their experiences of the clinic. These experiences were shaped more strongly by other factors. This finding complicates the results of previous studies, which suggested a deterministic propensity of integration on attendees' experiences. So, what might account for the divergence in findings from this study when compared to pre-existing evaluations? This, I believe, is explained by the ethnographically-informed methodology of this study. Allowing participants to narrate their own experiences, I learned that none of them spoke of attending an 'integrated' clinic. Instead, they reconstructed the clinic as aligned to their presenting need – a 'GUM clinic', an 'STI clinic', a 'family planning clinic', a 'well-woman service', and so on. This finding reminds us that there is the potential for discord between the *intention* of space and the *perception* thereof, by which I mean, while the clinic's design and organisational function were fully integrated, this went unnoticed by those for whom it was built. So, while pre-existing studies of integration were premised on the assumption that the integrated remit of services would be recognised, known and perceived, the findings from this research show clearly that, when not prompted on the issue of integration, it goes largely unnoticed. Furthermore, the findings remind us that buildings

cannot simply be. They are mutable and subject to collective and individual reconstruction (Hollis 2010; Collins 2007; Gieryn 2002).

This complicates the picture presented by some of the existing studies on integration, which sought to gauge attendee expectations or reactions to integrated facilities. In many of these studies, participants were made aware of and asked to focus on the integrated nature of the facility, an approach which my research suggests may not capture the actual experience of many attendees. Since many of the studies were evaluations performed by the One-Stop Shop Evaluation team in a short time frame, their approach was understandably constrained. My findings show the differences between measuring attitudes towards policy, which often necessitates narrowing participants' focus on a single issue, and exploring attendee experiences of place ethnographically. This latter approach allows for the emergence of new and unanticipated insights (Chapter 3). As I found over the course of my own research, people impose their own perspectives, making it hard to pin down exactly how someone does or does not "experience" integration.

With the integrated organisational structure of the facility proving a relatively moot point among participants in this research, the question of what influenced their experiences of an integrated clinic remained. In chapters 8 and 9, I argued that participants' experiences were borne of a combination of influences located within and outside of the clinic's walls.

10.2 The meaning of space: Configurations and reconfigurations of the clinic

This study found that participants' experiences of the facility were strongly shaped in advance by their preconceptions of the facility, personal biography, prior experiences of the care pathways, and social narratives of stigma attached to sexual health. Once they arrived at the facility, these preconceptions were then challenged, confirmed and reshaped by the affective propensity of the clinic's 'therapeutic landscapes' (Gesler 1992). In this way, attendees reconfigured the clinic as an intimately personal experience that is nevertheless highly contingent on broader social narratives.

Participants' accounts of their time at the clinic appeared to be influenced by forces external to the facility itself. In particular, discourses of personal responsibility and stigma linked to reproductive control and sexually transmitted infections featured prominently. This came out

in preconceptions about what the facility would be like ('grotty'), a reluctance among some participants to tell close friends about their visit ('embarrassing'), and feelings of anxiety about who the clinic was for ('young people'). Also, attendees perceived themselves as having an acute need. As a result, they wanted to 'get in and get out' as quickly as possible. This led participants to be cooperative in their interactions with healthcare practitioners, behaviour which I link to broader bio-political notions of responsible self-care, and the individual strategic investment in self-actualization – to do the right thing for self and society. These findings support the understanding that the modern clinic is no longer an 'island', cut off and isolated from wider society, but a reflection and reinforcing site within dominant social and cultural practices (Street and Coleman 2012; Long et al 2008; van der Geest and Finkler 2004).

When attendees arrived at the facility, these preconceptions were reinforced or reconfigured by the affective landscapes within the clinic. As discussed, the affective landscapes are a combination of social, symbolic and physical elements that, together, have the propensity to generate experience. As a purpose-built facility, the space was engineered by designers and clinic staff to create a clinic that was fit for purpose, but also one that was welcoming, open and non-judgemental. Attendees' experiences suggest that balancing these needs was difficult and only partially successful.

The foyer was seen as being far too small, exacerbating the sense of social awkwardness. It signalled to them that this was a different type of healthcare facility. The lack of chairs and sitting on the floor would not be acceptable in other sites. The laminate numbered card was a symbolic source of a sense of dehumanization and great uncertainty about whether they were welcome at the facility. This anxiety about belonging was felt particularly strongly by those who had been unable to get the care they needed from their GP, but who questioned whether their need would be considered 'urgent', as the language on the laminate card indicated. This experience of liminality and social confinement exacerbated the anxieties attendees of the walk-in care pathway often felt due to preconceptions of stigma attached to the service and the acute personal health concerns they were addressing.

The social landscape, in terms of other people at the clinic, was almost always experienced as awkward and even somewhat intimidating. For some, it was a surprise that the service was co-ed. For others there was a sense that the service was mainly catering to 'young people'. In

most accounts, attendees expressed a desire to ‘keep their heads down’ and disengage from the waiting spaces so as to preserve a sense of invisibility. I argue that this desire to pass through the clinic quickly, quietly and invisibly is a sign of the impact of personal and social preconceptions of sexual health. The social awkwardness of the waiting spaces stands in contrast to the interactions with staff, with participants indicating far more positive experiences, and a sense of being welcomed, well cared for and treated without judgement.

In general, however, it was the physical landscape that played an inflated role in participants’ accounts of their experiences of the clinic, both positively and less so. Once beyond the foyer, the entry space which certainly only served to exacerbate feelings of stigmatisation and difference, through the negative confluence of the physical, symbolic and social landscapes, most attendees found the aesthetics of the clinic to be pleasing, even therapeutic in some cases (Jules Chapter 6). The modern interior, bright colours and airy atrium countered their expectations of a service that they perceived as stigmatised in society, and inevitably ‘grotty’. Indeed, as Penny’s comment attests (Chapter 6), the facility gives off a very different counter-narrative through its affective landscapes. In this way, the clinic’s physical landscape works to challenge the preconceptions attendees accrue outside of the facility, effectively seizing the opportunity to reconfigure the clinic and improve patient experiences.

These findings demonstrate how attendees’ experiences were shaped by the multi-faceted affective landscape of the clinic. Although much of their experience is influenced by the personal and social history of sexual health outside of the clinic, these preconceptions can be challenged, confirmed or reconfigured by the social, symbolic and physical landscapes of the facility. This study shows that to be the case even in an outpatient facility in which transient populations spend only short periods within the clinic.

10.3 Therapeutic landscapes in outpatient services

Much of the existing research examining the relationship between environment and patient wellbeing has been focused on inpatient facilities. Outpatient services have been largely overlooked, based on the assumption that patients who don’t spend much time at the facility won’t be affected by its environment. What participants in this study indicated strongly to me was that the affective landscapes mattered in their experiences of attending Chalmers. This finding is significant as it fills a gap in the deployment of Gesler’s (1992) conceptual

framework of the ‘therapeutic landscape’ which, to date, has not been applied to a transient, ‘walk-in’ service. Further, this research suggests that the physical landscape is even more important in the case of stigmatized ‘walk-in’ services. When there is little opportunity to cultivate therapeutic social relationships, in a context where there is a keen awareness of the social stigma associated with the service, the physical landscape can work to provide a counter-narrative to the discourses of stigma that permeate from the outside.

This research has provided a unique insight into the experiences of attendees to a fully integrated sexual and reproductive healthcare facility, through the application of innovative methods. When taken together, participants accounts point to the facility as being a place of significant meaning, as a remedial space where the recalibration of risk perception is fostered and reassurances made; a space for exercising choice and autonomous reproductive decision-making; a space wherein hope for the future lies. In these imaginations of the clinic, integration was largely absent.

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Appendix 1: QIT Project Proposal

| PROJECT PROPOSAL AND REGISTRATION FORM | |
|---|--|
| <p>Please see sections in the workbook for guidance on completion of the form.</p> <p>Please note - your form will be returned if any section is blank.</p> | |
| <p>Project Title: <i>(include population, condition and intervention – see section D)</i></p> <p>Integrating sexual health services: A qualitative evaluation of attendee and staff experience.</p> | |
| <p>Why was the project selected? <i>(e.g. “Implementation of SIGN Guideline” - see section C)</i></p> <p>To evaluate a new service</p> <p>Chalmers Health Centre is a purpose-built integrated sexual and reproductive health care facility. Therefore, it houses both GUM and FP services which, prior to integration, were separate services and professions.</p> <p>To evaluate user/ carer satisfaction</p> <p>Given the integrated environment for accessing sexual and/or reproductive health care it is important to assess stakeholder (attendee and staff) experiences of the facility.</p> | |
| <p>Objective(s): <i>(Why are you doing the project and what do you hope to achieve – see section E)</i></p> <p>The study will contribute to knowledge regarding attendee experiences of integration. To date, the majority of such research has been conducted using quantitative means. Introducing qualitative, inductive methods will uncover unanticipated insights which, in turn, may be used to inform future service development at Chalmers and other similar facilities.</p> | |
| <p>Appropriate Quality Improvement Team <i>(see section I)</i> Family Planning Services</p> | |
| <p>Main project contact:</p> <p>Name Sarah Jeavons</p> | |

| | |
|-----------------------------------|---|
| Job title | PhD candidate, Centre for Population Health Sciences, University of Edinburgh |
| Service (<i>see section U</i>) | N/A |
| Division (<i>see section T</i>) | N/A |
| Phone number | 07450299054 or 0131 651 7112 |
| E-mail address | S.E.Jeavons@sms.ed.ac.uk |

| | |
|---|--|
| Supervisor | |
| Name | Professor Julia Lawton, Dr. Jeni Harden and Professor Anna Glasier |
| Job title | Main academic supervisor, second academic supervisor and expert supervisor |
| E-mail address | j.lawton@ed.ac.uk , jeni.harden@ed.ac.uk , anna.glasier@ed.ac.uk |
| In addition, the study has been designed in consultation with senior staff member at Chalmers – Dr. Ailsa Gebbie (Ailsa.Gebbie@nhslothian.scot.nhs.uk) | |

| | |
|---|--|
| Methodology (<i>brief outline</i>) (<i>see section F</i>) | |
| <i>(please attach any relevant documents such as the data collection form, interview schedule, consent form etc)</i> | |
| <p>The study will be conducted at the Chalmers Health Centre in Edinburgh. A mixed-methods qualitative approach will be adopted for the purpose of the study comprising of observations and in-depth interviews with attendees and staff. These methods have been chosen to allow the researcher to understand and explore people's experiences of integration at Chalmers. The project researcher – Sarah Jeavons – has an honorary research contract until October 2014. Introduction to Chalmers was facilitated through Dr. Ailsa Gebbie during February and April of 2013, during which time Sarah observed various care pathways and met staff members.</p> | |
| The process | |
| <p>Attendees (both 'walk-in' and booked appointment holders) will be included in the study. Participants will be asked for their permission for Sarah to accompany them on, and observe their journey through Chalmers and then participate in an in-depth interview at the end of their visit in order to talk about their experience. Interviews will include the following areas of enquiry (appendix 1):</p> <ol style="list-style-type: none"> 1. Reasons for attending Chalmers 2. Decision-making regarding the chosen pathway (why opt for 'walk-in' or booked). 3. Preconceptions of the facility. | |

4. Experiences of attending; likes and dislikes of the services and information received; differences between expectations of the services and actual experiences.
5. Views on the various spaces within Chalmers.
6. Ideas for improvement of services.

Observations of staff will occur as a consequence of the researcher accompanying attendees during their time at Chalmers. These observations will be restricted to staff's interactions with attendees (e.g. in consultations) who are taking part in the evaluation. Staff members will also be invited to take part in an in-depth interview, in order to ascertain their views on integration-in-practice. The initial topic guide for these interviews will include the following questions (appendix 2):

1. Previous specialism (FP or GUM), if any.
2. Views on integration policy and preconceptions regarding the implementation of integration at Chalmers.
3. Experiences of working within Chalmers, with possible comparison to experiences in services prior to integration.
4. Views on the various spaces within Chalmers.
5. Ideas for improvement of services.

Recruitment

Recruitment will be approached through various means, and will be staggered to allow for concurrent data collection and analysis. Recruitment will be facilitated in liaison with staff who will be briefed as to the study's aims, and the procedures involved in recruitment.

'Walk-in' attendees will be recruited through the use of recruitment materials, as well as triage staff at Chalmers. An A1 or A0 participant information poster (appendix 3) will be installed in the foyer so that 'walk-in' attendees are made aware that the evaluation underway. The poster will briefly outline what the study is aiming to achieve and what would be required if an attendees is interested in taking part. Once within triage, an oral invitation to participate will then be extended to individuals, by the triage nurse. If an attendee expresses an interest in participating, the triage nurse will introduce the individual to the researcher in order that they can talk through the participant information sheet (appendix 4). This interaction will also allow for the attendee to ask any questions they might have prior to consenting. If, after discussing the study, the participant is happy to proceed, they will be provided with, and asked to sign a consent form (appendix 5).

Individuals with booked appointments at the IUD/IUS clinic will be invited to participate in the study through the use of postal information packs. The packs will be addressed and posted out by a staff member at Chalmers, in order to safeguard the information of women who choose not to participate. The recruitment pack will include a participant invitation letter (appendix 6), participant information sheet (appendix 7) and an opt-in form (appendix 8). There will also be a stamped addressed envelope provided, with which those wanting to participate can return their 'opt-in' slip. In addition, the pack will include a cover note from a staff member at Chalmers, confirming the appointment and introducing the study as on-going, and voluntary. Those wishing to take part will be contacted prior to their appointment (using the preferred means of contact indicated on the 'opt-in' slip) in order to confirm their intention to participate, and to arrange a place to meet at Chalmers. Having met with the attendee, the researcher and the appointment holder will spend time going through any further questions which the attendee may have, before they complete the consent form (appendix 9).

In all instances recruitment and participation will be influenced by the principle of process consent. This means that participants will be able to opt-out at any stage of their participation and also choose the extent to which Sarah is present (for example, a participant can ask that Sarah is not present during the clinical consultation).

Staff will be recruited through the use of an information bulletin in the internal *Chalmers Weekly* newsletter. The bulletin (appendix 10) will inform staff to the commencement of the study, while also notifying them that they will each receive a participant information pack, made up of a participant information sheet (appendix 11) and an informed consent form (appendix 12). Clear instructions will ask staff who consent to participate to return the form to one of the sealed 'post-boxes' which will be placed throughout the staff spaces within the facility, such as the break room and the doctor's room. Finally, Sarah will attend internal staff meeting - 'Protected Learning Session' (scheduled for December 17th) - at Chalmers, in order to formally introduce the study to staff and answer any questions they may have. This forum will also provide an important opportunity to follow-up on consent forms, if necessary. This type of recruitment has been used in other studies and proven successful.

Sample

Approximately 40–50 participants will be recruited to participate. This sample size has been determined so as to allow for a diversity of experiences and views to be captured and explored in-depth, and for data saturation to occur in key areas (meaning, the point to be reached where no new findings or themes arise from new data collected). In addition, the sample size has been estimated in relation to feasibility. The volume of data which observation and in-depth interview methods generates is significant. An important balance is needed in ensuring that the sample size is neither too big in terms of the feasibility of extracting findings from substantial amounts of data, while being large enough to reach saturation.

The attendee sample will be comprised of approximately 24 -30 participants. Having consulted with senior health professionals at Chalmers, and responding to gaps in knowledge relating to attendee views of integration at the facility, the study will focus on inclusion of the following:

1 'walk-in' attendees

2 booked appointment holders for the IUD/IUS clinic.

3 staff members from GUM and FP backgrounds, as well as those working in non-clinical, administrative roles. An estimated staff sample size is 12-15.

Exclusion criteria for this study:

1 – Those under the age of 16.

2 – Those assessed by triage as vulnerable.

3 – Those who are not able to understand relevant study information – (for example those without a strong grasp of the English language).

Data collection

Data for study purposes will be managed using two methods: field-notes and audio-recordings. Primarily, field-notes will be the product of observations, while audio-recordings will document conversations during in-depth interviews. Analysis will not be left until the end of the fieldwork stage but will be on-going simultaneously to fieldwork and will inform the development of the study. Themes which are identified in

each interview, and ideas borne of observations, will be used to inform the focus of subsequent interviews and observations. In this way, analysis will be an inductive process.

Date analysis

Data analysis will be on-going simultaneously to data collection. Transcripts of interviews will be made, and re-read in order to familiarise the researcher with the findings and embark on the process of coding identified themes. Themes will likely comprise both those linked to original research questions as well as unanticipated findings. As they are identified, themes will be coded in order to allow for easy retrieval of data. This stage will be managed through the creation of folders on Sarah's computer, which will hold copies of relevant passages from field-notes and interview transcripts. In addition, qualitative data software Nvivo will be used to search, retrieve and link findings. Throughout the process of analysis, Sarah will be guided by her academic supervisors.

Data storage

Data generated over the course of the study will be accessible only to the researcher. Consent forms and 'opt-in' slips will be attributed with a participant ID pseudonym by the researcher, and then locked in a drawer on the University of Edinburgh premises, separated from transcriptions and field-notes. All transcriptions and field-notes will refer only to the pseudonym of participants. These documents will be stored, either, in a dedicated locked filing cabinet within the researcher's office at the University of Edinburgh (hard copies) or on a password protected computer, to which only the researcher has access (electronic formats). This computer is located within a locked office at the University of Edinburgh. Devices used for data collection (tablet for field-notes, and audio-recorder for interviews) will be stored alongside the hard copies.

All files relating to the research will be destroyed within 5 years of the completion of the study. This means that all hard copies will be shredded and all electronic copies of audio-recordings or field-notes will be deleted from the computer hard drive as well as the tablet hard drive.

Estimated start date:

Estimated completion date:

(day /month /year):

...18/12/2013

(day /month /year):

10/10/2014

| Confirmation that the governance topics in this workbook have been addressed (✓): | Brief explanation if the governance topic is considered to be not applicable |
|---|---|
| ✓ · Other people involved (Section H) | |
| ✓ · Literature search (Section J) | |
| ✓ · Resources (Section K) | |
| ✓ · Ethical considerations (Section L) | |
| ✓ · Equality and Diversity (Section M) | |
| ✓ · Consent (Section N) | |
| ✓ · Data protection (Section O) | |
| · Caldicott principles (Section P) | Not applicable as the study does not require access to patient records. The study will ensure that information gathered will be kept strictly confidential and anonymized for data protection purposes. |

Please complete the form and send it to your QIT contact (or to Steve Richer at CGST if there is no obvious QIT for your service - see list in Section I of the workbook (or intranet) for details. Thank you.

Appendix 2: Feasibility study



Chalmers Centre are always keen to find new ways to improve services. To do this, it is important to learn more about your experiences here. I would be very grateful if you could spend a few minutes reading about one of the new ideas for understanding your experiences at Chalmers.

You are not being asked to take part in the study. Instead I would just like to know what you think about the approach which is outlined below.

Allowing a researcher to accompany you to your appointments

A study on patient experience is being done. A researcher hopes that you will let her accompany you throughout your visit to Chalmers, including your appointments with the nurse or doctor, as well as sitting with you in the waiting room.

The researcher wants to learn about **how you think and feel** during your visit. She would take notes on what you say to her, but would never ask for your name or age. She would make sure that none of the notes could identify you. You could ask her to leave at any time during the visit, if you felt uncomfortable.

At the end of the visit, the researcher would give you her email address. You could contact her and ask her not to include your experiences in the study, if you later change your mind.

Based on the above situation please tick (✓) the statement you most agree with:

1. I would allow the researcher to accompany me during my visit to Chalmers, ☐
based on the understanding that I could change my mind at any point ☐
during, or after, participation.
2. I **would not** allow the researcher to accompany me during my time at the
Chalmers.
3. I am not sure/it depends (please give a reason, if you can) ☐

.....
.....
.....
.....
.....

Please **do not put your name** anywhere on this form.

Just tick the appropriate statement

and then return the form **to the box in main reception**

Thank you for your time.

Appendix 3: Topic guide attendees



Objective –

- To explore and evaluate the ways in which attendees experience Chalmers.

Introduction –

Thank you for taking part in the interview. I am interested in learning about your experiences of coming to Chalmers – **what you think and feel about your visit.**

[go through this in order that the participant can decide whether they would like the audio recorder or not] The interview can be audio recorded or written notes can be taken only. **The choice is up to you.** If you choose to go ahead and allow me to audio record the interview, you will be able to turn off the recorder at any point, should you choose to do so. In all instances (recorded or notes) you may choose to refrain from answering a specific question or, indeed, stop altogether.

[Turn on the audio recorder, if that has been agreed to]

[to get this on the record – to reiterate] So, would you be willing to state that you have agreed to having the interview audio recorded, based on the fact that you can control the device, can turn it off whenever you like, and that it will remain confidential and anonymised?

In addition, throughout the course of the interview, if you would like to ask me any questions then please feel free to do so. However, it is important that you understand that I am not a representative of Chalmers and, therefore am not able to speak on behalf of the facility.

So, if you are happy, let's get started!

1. Ok, so this interview is interested in **learning about your thoughts and feelings about attending Chalmers today**. I am interested in your **experiences of the facility and the care you have received** today. The questions will focus on **asking you about your experience, rather than the medical reasons for you attending**. In all instances your responses will remain **confidential, and anonymous**.

Reasons for attending/choosing Chalmers

Talk me through why your decision to Chalmers today.

Have you been here before?

[If yes]: How did you hear about Chalmers the first time?

Why did you come back to the service?

[If no]: How did you hear about Chalmers?

Why did you choose the service?

Did you know about the alternative possibility to ['walk-in' or **book**]?

What is your understanding of the sort of service provided here at Chalmers?

Did you look at the website at all?

Have you been to any other sexual and/or reproductive health service before?

[If yes]: Where was the service?

How long ago did you attend?

How did it compare to your visit to Chalmers?

2. Preconceptions of the facility

Did you have any ideas of what the place would be like, before you came here?

[Link to earlier question - if the interviewee has attended before, ask whether they think that the facility has changed at all since their last visit, and if so, in what ways]

How did you feel before you arrived?

Why do you think you felt [use the word they used]?

Did you think about what the consultation would involve?

Did you have any expectations about what it to be like?

Why do you think you had that expectation? [possible prompt – from friends who have attended/from watching TV shows such as ‘unsafe sex in the city’]

Did you tell anyone that you were coming here?

[If yes]: who did you tell?

What reasons did you have for telling them?

What was their response?

How did their response compare to the one you were expecting?

[If no]: Why not?

Now that you have been, will you tell anyone?

[if yes] Who will you tell and why do you think you would tell people now?

[if no] Why?

3. Experiences of attending

Talk me through your experience of attending Chalmers today

How long have you been here today?

What time did you arrive?

How does this length of time compare to how long you expected to be here?

What did attending Chalmers mean for you? Is this an important, or meaningful, place for you?

Compared to your expectations, how was your experience?

And tell me more about the clinical consultation in particular – what was that like for you?

Has coming to Chalmers changed the way you were feeling?

 If so, how?

4. Views on the various spaces within Chalmers

Thinking about the various spaces you have been through today at the clinic, could you tell me a little about how you felt in each of the areas of the facility?

Why do you think you felt that way in the various rooms?

Did you have to wait in the foyer before the reception opened?

[if yes] how did that space feel?

How did it feel being in the waiting rooms?

Did you notice any of the information posters/leaflets around?

[If yes]: did you read any of them?

[If yes]: How did they make you feel?

[If no]: why didn't you read them?

Did you notice any of the art in the building?

[If yes]: what did you think of it?

5. Ideas for improvement of service

Is there anything about the service you experienced which you think could be changed for the better?

[if yes]: In what ways do you think [that – their suggestion] would help improve the service?

6. Endings

Talk me through your motivation for taking part in this study?

Assumed it would be harder for people in terms of shyness or whatever

Is there anything else you would like to add? Something that I have not asked you that you would like to mention?

Background: - demographic details

Would you mind telling me the decade of your birth?

and how would you describe your ethnic origin?

Now, how far, approximately, did you have to travel to come here today?

And how did you make that journey?

What do you think of the location of Chalmers?

48 hours to change your mind.

In addition, if you would like a copy of the report I'll produce then you can either contact me, or I can contact you with it.

Appendix 4: Topic guide staff



Objective –

- To explore and evaluate the ways in which you experience Chalmers.
- To understand how you think integration has impacted on attendee experience

Introduction –

This interview focuses on three main parts:

1. Your views on integration policy
2. Your experiences of integration-in-practice
3. Your insights with regards how your patients experience Chalmers

Background: -

What is your job title?

What does that entail?

How long have you worked at Chalmers?

Do you have previous experience of working within a ‘stand-alone’ FP or GUM service?

[if yes]: FP or GUM?

For how long were you working in that specialism?

[if no]: where were you working before coming to Chalmers?

Section One: *Views on integration policy*

As a lay person, how would you describe integration to me?

What were the presumed benefits of integration?

And weaknesses, if any?

Specifically, why was integrated care opted for in Edinburgh?

Talk me through what the move to Chalmers was like – what did it involve?

How did you experience that?

Based upon this first section, on the rationale behind integration policy, is there anything you'd like to add?

Section two: experience of integration-in-practice

Talk me through what an average day is like for you

Is there anything that you do now that you didn't do, prior to integration?

If so, what?

How does working at Chalmers compare to where you were in the previous location?

Has integrated care provision changed the way that you experience your job at all?

If so, how?

In your view, how do you think integrated care is going in Chalmers?

Has Chalmers changed at all since opening?

If so, in what ways?

Is integrated care synonymous to complex care here at Chalmers?

Do you think that any changes could be made in order to improve the working environment for staff? If so, what changes would you suggest?

Again, thinking about your experiences of integration, is there anything you'd like to add?

Section 3: Insights regarding patients

In a consultation, how do you implement the integrated approach?

Has integration resulted in any changes in the way you interact with patients?

Is there anything you do in order to try and make patients feel at ease when you see them?

What is your impression of how patients you see experience Chalmers?

Do you get the impression that patients realise this is an integrated facility or otherwise?

Do you think that is important?

Do you get the impression that patients are bothered, one way or the other, about this being an integrated space?

Do you think that any changes could be made in order to improve the service offered to attendees? If so, what changes would you suggest?

In terms of the environment, do you know who chose the radio to be played?

Endings

Is there anything else you would like to add? Something that I have not asked you that you would like to mention?

Appendix 5: Topic guide stakeholders



Objective –

- To gather first-hand accounts of the motivations for, and the vision of, integration at Chalmers.

Introduction –

Thank you for taking part in the interview. I am interested in learning more about the motivations for creating an integrated sexual and reproductive health care service at Chalmers.

At any time during the interview you can choose not to answer a question and, if you feel that you want to stop altogether, then that is fine. I will also leave the audio-recorder on the table close to you, so if you would like to turn it off at any point, please do so. If you would prefer that the interview is not recorded, then I can take notes instead.

N.B: the topic guide will develop inductively. The following questions, then, will be added to or adapted if necessary.

Reasons Chalmers was established

Why was Chalmers set up?

Why was Chalmers established on the site where it stands?

How was Chalmers funded?

What was your role in the Chalmers project?

Insights into the design philosophy of Chalmers

What do you know of the design philosophy of Chalmers? [possible prompt – the reason for creating, for example, the large atrium/the grass rooftop].

What do you think of the finished facility, in terms of its design?

Views regarding the intended uses for the service

How did the project board envisage that Chalmers would be used? By whom? What needs would it address?

Do you know whether Chalmers, now open, is being used as it was intended? By the people it was intended to serve?

Endings

Is there anything else you would like to add? Something that I have not asked you that you would like to mention?

Appendix 6: Form to NHS Scientific Officer

1. Has this protocol been submitted to any other NHS ethics service/committees?

No.

2. Is the project funded and by whom?

It is a College of Medicine and Veterinary Medicine PhD Studentship, with funding supported by the Medical Research Council (MRC) Doctoral Training Grant.

From the patient point of view:

3. Does your project involve changing treatment/patient care from accepted standards?

No.

4. Who would be conducting the project and are they members of the participants' health care team?

The research will be conducted on a full time basis by the sole investigator, PhD researcher Miss Sarah Jeavons. Sarah is based at the Centre for Population Health Sciences at the University of Edinburgh, and will conduct her PhD project under the supervision of Professor Julia Lawton, Doctor Jeni Harden and Professor Anna Glasier. Sarah is not a member of the participants' health care team.

5. How are you identifying the participants?

Through liaison with staff at the facility.

Booked appointment holders: through a staff member who will select suitable participants and send out the study information packs.

'Walk-in' attendees: through the triage nurse, who will identify suitable participants and ask them if they would like to participate in the research.

6. Will there be any accessing and/or processing of patient identifiable information, including by the study sponsors for audit purposes?

Yes. But limited, and only accessed with the express consent of the participant.

No information will be accessed by the researcher prior to gaining consent. In the case of postal invitations to participate in the research, a staff member at the facility will take on the role of addressing envelopes to send out, rather than the researcher. For those who opt-in to the research, they will be given the opportunity to provide a false name, and to sign their consent form using this alias. Further, it will not be mandatory for participants to provide any contact information to the researcher. Approximate age (year of birth) will be asked during the interview stage of the research, but this, again, is not mandatory.

7. How and by whom will this be undertaken?

Identifying patients for postal pack – staff member, not researcher.

Addressing postal pack – staff member, not researcher.

Collecting 'opt-in' forms, consent forms – researcher.

8. Will anybody outwith the participants' health care team have access to patient identifiable information without consent?

No.

Appendix 7: NHS Exemption letter

South East Scotland Research Ethics Service

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG



Name: Sarah Jeavons
Address: Centre for Population
Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh
EH8 9AG

Date: 30/10/2013
Your Ref:
Our Ref: NR/1310AB18
Enquiries to: Alex Bailey
Direct Line: 0131 465 5679
Email: alex.bailey@nhslothian.scot.nhs.uk

Dear Sarah,

Project Title: Integrating sexual health services: A qualitative study of attendee and staff experience

You have sought advice from the South East Scotland Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (email correspondence, Revised Protocol 15 10 2013.docx, form from Alex.docx), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees (A Harmonised Edition).

The advice is based on the following:

- *The project is a survey seeking the views of NHS staff and patients on service delivery*

If the project is considered to be research you may require ethical approval as outlined in The Research Governance Framework for Health and Community Care. You may wish to contact your employer or professional body to arrange this. You may also require NHS management permission from host care organisations (R&D approval). You should contact the relevant NHS R&D departments to organise this.

For projects that are not research and will be conducted within the NHS you should contact the relevant local clinical governance team who will inform you of the relevant governance procedures required before the project commences.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that NHS ethical approval is not required. However, if you, your sponsor/funder feels that the project requires ethical review by an NHS REC, please write setting out your reasons and we will be pleased to consider further. You should retain a copy of this letter with your project file as evidence that you have sought advice from the South East Scotland Research Ethics Service.

Yours sincerely,

Alex Bailey
Scientific Officer
South East Scotland Research Ethics Service



INVESTORS
IN PEOPLE



Healthy
Working
Lives

1

Headquarters
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair: Mr Brian Houston
Chief Executive: Tim Davison
Lothian NHS Board is the common name of Lothian Health Board

Appendix 8: Letter from University REC stating points of concern



THE UNIVERSITY *of* EDINBURGH

CENTRE FOR POPULATION HEALTH SCIENCES

Ethics Review Group

Medical School

Teviot Place

Edinburgh EH8 9AG

Telephone 0131 650 3239

Fax 0131 650 6909

email: cphs.ethics@ed.ac.uk

23 June 2016

Dear Miss Jeavons

Re: Integrating sexual health services: A qualitative evaluation of attendee and staff experiences

The above study has been reviewed by the CPHS ethics committee and we are pleased to grant ethical approval, subject to the following conditions:

1. It was not clear from the protocol why the researcher needed to be with the participant *during* the consultation. The aim and questions seemed to be primarily focussed around the use of the facility, whereas researchers normally sit in consultations to understand more about the interactions between patient and staff. It is not clear what additional important information (to achieve the research aim) would be obtained in the consultation over and above the interview after the consultation. A clear justification needs to be given for this step, as it could be an embarrassing and unnecessary intrusion into the consultation for the participant and it seems to go beyond the normal scope of an evaluation. Further justification also needs to be provided as to why the interview needs to be undertaken directly after the interview (see point 2).

2. Section 3 of the ethics review form. The researcher notes that the participant might be upset by some of the information that might be disclosed during the consultation, it is not clear why the researcher has to undertake the interview directly after, and not at a time convenient to the participant.
3. No NHS ethical approval appears to be being sought – if this is because it is an evaluation, a letter from NHS ethics stating that ‘no approval is necessary’ needs to be obtained
4. Appendix 4. The poster needs to be made clearer. For example, it is not clear that by taking part a person must consent to 1), 2) *and* 3) – they could be read as options. In 2) – ‘exam’ may not mean the same to a person as it does to you – need to make clear it is examination. I found the people and the conversation a bit confusing with speech bubbles reporting both third person speech and first person speech.

Please submit the revised documents to the Ethics Review Group, via me, prior to commencement of data collection. Please provide a covering letter indicating how you have addressed the above points, and track any changes made to the documents you resubmit, this will ensure that we have an accurate record of all study documentation, as (conditionally) approved.

Yours sincerely

Lesley McGoochan

Ethics Review Group Administrator

Appendix 9: Response to points raised by CPHS REC

Sarah Jeavons
Centre for Population Health Sciences
Medical School
Teviot Place
Edinburgh
EH8 9AG

0131 651 7112

Email: S.E.Jeavons@sms.ed.ac.uk

3rd December 2013

Response to Ethics Review Group conditional approval (dated 26th November 2013)

Thank you for the recent conditional approval for my proposed study at Chalmers Health Centre. This letter details my responses to the points raised. Updated documents are attached.

In response to the query about the researcher being present *during* the consultation, please consider the following points:

- a. **In all instances participants will determine the extent of their participation, and my presence.** In practice, this means that a guiding principle of process consent has been embedded into the research design. Therefore, should a participant take the initial decision to allow me into the consultation room they will be asked again - shortly prior to entering their consultation. This will provide participants with the opportunity to change their mind. If granted access into the consultation room, should anything occur which makes the participant embarrassed or upset, I will offer to leave the room. In addition, any instance in which a participant asks me to leave will be respected. Consequently, care has been taken to ensure the participant controls the extent of their participation, and this includes whether they wish to allow me into the consultation room or not. This decision is made based upon the belief that while some participants may find attending Chalmers an embarrassing experience, others may not.
- b. Having addressed how I hope to allow for participant choice in the extent of their participation while also striving to minimize harm, I will now respond to the question about what '*additional important information*' my presence during the consultation would provide. As demonstrated in the proposal, the study is focused on better understanding attendee and staff experiences of integration. **A key space within Chalmers wherein integration policy is put into practice, enacted and experienced is the consultation room.** While participants will be able to recollect their experiences

of the consultation in interview, relying upon their retelling of experience will be subject to omissions of detail. Thus, in order to better understand the experience of a clinic journey, I hope to attend to the temporal orientation of experience³³. Through accompanying participants on their clinic journey, it will be possible to observe verbal and non-verbal reactions to Chalmers in stages of anticipation (the waiting rooms), the moment (the consultation room) *and* in recollection (the interview). Through observing this entire temporal range details gathered may uncover insights that would have gone otherwise unobserved. Given that this study is somewhat exploratory, most notably in its attempts to engage 'walk-in' populations in a qualitative, inductive evaluation, it may be subject to a small sample (the fact that – put bluntly, recruitment might be difficult). Therefore, it is important to ensure that the methods employed have the potential to generate rich insights. In this instance, the use of observations and interviews is the best way to achieve this goal.

In response to the second point about the interview being held on the day or at a later time (especially in relation to participants upset by the consultation experience), please consider the following:

- a. It is the position of the researcher that **in all instances** the participant has the *option* to: opt-out completely from the interview; go ahead with the interview; or re-schedule the interview for a time and place of their choosing, as stated on pages 8 and 9 of the proposal (submitted 6th November 2013). If someone is upset by their consultation, they have the opportunity to reschedule or opt-out completely.

In response to point three of the Ethics Review Group letter, asking for the NHS letter stating that 'no approval is necessary' from NHS Ethics, please find the requested NHS letter attached to this re-application (attached as part of this re-submission).

In response to point four please see an amended poster (Appendix 4). The word 'exam' has been changed to 'examination' and the speech bubble also amended for clarity. The information boxes (1,2 and 3) have not been amended at this time. This is because it is not, in fact, obligatory that participants take part in all aspects of the study. As discussed in this letter and the proposal, should someone express a wish to participate, but suggest that they would not want me to accompany them into the consultation room (information box 2 on the poster) then this would not exclude them. The numbers and information boxes indicate options which the participant will determine as they go along and, therefore, this is desirable.

³³ Throop, C.J (2003) Articulating Experience in *Anthropological Theory* 3 (2).

I thank you kindly for your consideration of my responses to the points raised in the conditional approval letter.

Yours sincerely

Sarah Jeavons.

Appendix 10: CPHS REC Approval letter



THE UNIVERSITY *of* EDINBURGH

CENTRE FOR POPULATION HEALTH SCIENCES

Ethics Review Group

Medical School

Teviot Place

Edinburgh EH8 9AG

Telephone 0131 650 3239

Fax 0131 650 6909

email: cphs.ethics@ed.ac.uk

16 December 2013

Dear Miss Jeavons

**Re: Integrating sexual health services: A qualitative evaluation of attendee
and staff experiences**

Thank you for resubmitting your documentation with the amendments that were requested by the CPHS ethics committee. The amendments have been judged satisfactory. I am therefore pleased to be able to inform you that the above study have been granted ethical approval.

Please be aware that this ethical approval is in respect of the protocol and methods as described in the documents submitted to the committee (with amended documents superseding predecessors). If there is in the future *a change* to the study design/protocol/methods, you should check whether this means your level 2 application form needs to be revised, and submit to the committee (via me), any documents that have been revised (study materials/protocol/level 2 form), using tracked changes. You should make clear in your covering email whether:

- (i) you are requesting ethical review of a study amendment; or
- (ii) you are not sure whether such is needed and, in the first instance, would like the committee's opinion on whether a formal approval is needed of the amended design/methods.

Yours sincerely

Appendix 11: 'Opt-in' form – booked appointment holders



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

If you would like to take part in the evaluation, please fill out this form and return it in the stamped addressed envelope provided by **Friday October 17th**.

Name, or alias [Please print].....

Date of appointment at Chalmers:

Time of appointment at Chalmers:

Contact details: [please provide one means of contact, if possible]

Telephone:

Mobile phone:

Email address:

Preferred time to call, if phone number provided:

If you have provided contact information, I will be in touch with you in the day before your appointment to arrange where to meet you at Chalmers on the day of your appointment.

If you would prefer that I don't contact you, then I will be at Chalmers on the day and time of your appointment, **in the main reception**. You can contact me before your appointment on my mobile, office number, or email address, if you have any worries or want to change your mind about taking part.

Sarah Jeavons

Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh
EH8 9AG
Tel: 0131 650 3043 /Mobile: 07450299054
Email: S.E. Jeavons@sms.ed.ac.uk

Appendix 12: Attendee (both 'walk-in' and booked appointments) informed consent



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

Participant ID [researcher to complete]

Thank you for reading the information sheet about the study. Please *INITIAL* the boxes if you agree to each statement.

1. I have read and understand the information sheet for the study. ()
2. I was able to ask questions about the study and felt happy with the answers I was given ()
3. I understand that taking part is up to me and that I can decide to stop at any time, without any reason, and without my medical care or legal rights being affected. ()
4. I understand that this study has been seen by the Ethics Review Group at the University of Edinburgh and has been approved. ()
5. I agree to taking part in an interview today and I understand that the interview will be audio-recorded and typed up. ()
6. I understand and agree to anonymized quotes from my interview being used in publications. ()

7. I agree to being part of an observational study today as part of my visit to Chalmers and I understand that notes about the visit will be taken and typed up. ()

8. I understand and agree to anonymized notes taken in the study being used in publications. ()

9. I understand who will have access to the data provided, that the data will be stored on a password protected computer at the University of Edinburgh, that my details will be fully anonymised and that all data will be destroyed at the end of the project ()

10. I agree to taking part in the above study.
If you agree with the statements above and want to take part, please fill in the details below: ()

.....

Name, or alias – PLEASE PRINT

.....

Signature

.....

Date

IMPORTANT:

You will have 48 hours after you have taken part to contact me, if you have decided that you have changed your mind and do not want to be included in the study. If you prefer, I can contact you.

Miss Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh EH8 9AG
Tel: 0131 650 3043 / Mobile: 07450299054
Email: S.E.Jeavons@sms.ed.ac.uk

Appendix 13: 'Walk-in' recruitment poster

My name is Sarah Jeavons

I am a researcher from the University of Edinburgh. I am interested in learning what you **think and feel** about your visit to Chalmers today.

You can take part by...

- 1 ...allowing me to sit with you in the waiting room before your appointment.
- 2 ...allowing me to go in with you to the doctor, but I'll leave for the examination.
- 3 ...agreeing to be interviewed about your visit to Chalmers today.

A nurse may ask if you would like to take part.



Sarah Jeavons

Researcher from the University of Edinburgh



Appendix 14: Participant information sheet ‘walk-in’



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

My name is Sarah Jeavons and I am a researcher from the University of Edinburgh. I am doing a research study to better understand what people **think and feel** about their visit to Chalmers. Please take the time to read through this information sheet. If you have any questions about anything written here, or if you would like more information, please ask for clarification.

What is the purpose of the study?

The purpose of this study is to better understand people’s experiences of attending Chalmers. The findings will be used to help improve the services offered at Chalmers.

Why have I been invited?

You have been invited to participate in the study because you have used the ‘walk-in’ service at Chalmers today. I hope to include about 15 people using the ‘walk-in’ service in this study.

What does taking part involve?

If you decide to take part in the study, you would be asked to:

1. Allow me to sit with you as you wait for your appointment with the doctor or nurse.
2. Allow me to come into the consultation room with you (I **would not need to watch any clinical procedures**, only the conversation between you and your doctor or nurse). **During the clinical procedures, I will leave the room.**
3. Allow me to take notes.
4. Take part in an interview, lasting about 30 minutes, at the end of your time at the clinic, which will be talking about how you felt about your visit. This

interview will be audio-recorded. If you do not want the interview to be recorded, I can take notes instead.

Do I have to take part?

No. You **do not** have to take part in the study. If you don't want to take part, that is fine. Your decision will have no impact on your medical care.

Will taking part be confidential?

Yes. Taking part in the evaluation will be anonymous and confidential. This means that:

1. You do not have to tell me your real name. You can sign the documents I give you with a fake name, if you want.
2. The name you give me will never be used in public. I will use a made up ID name instead.
3. All of the information collected when you take part in the study will be kept confidential (private) and will be stored in a locked filing cabinet or on a password-protected computer within a locked office at the University of Edinburgh.
4. The only person with access to this information is me.
5. All the files which relate to the study will be destroyed within 5 years of the completion of the study. The only person with access to the files will be the researcher, Sarah.

What will happen with the results of the evaluation?

The general findings of this study will be shared with Chalmers management and staff so that they can better understand what it is like for people to come to the 'walk-in' at Chalmers. It will not be possible for staff to know who said what. I expect to publish results in scientific and policy journals and to present findings to health care professionals.

If you would like a summary of the results, I can send these to you in the winter of 2015. You can get this summary by emailing, texting, or phoning me using the contact details below. If you would prefer, you can give me your contact details, and I will send you the results when they are ready.

Are there any benefits to taking part?

There are no direct benefits in taking part in the study, but I hope that you would find the experience interesting. Taking part will help to improve service delivery, and will provide you with the chance to speak at length about your views of the service.

Are there any disadvantages to taking part?

Taking part in the study means that you will need to be at Chalmers for about 30 minutes to one hour after your appointment with the doctor or nurse, so that you can take part in the interview. If you cannot stay an extra hour, it will be possible to arrange an interview on another day, at a place and time that you choose.

Who has approved the evaluation?

The evaluation has been reviewed and approved by the Ethics Review Group at the Centre for Population Health Sciences, University of Edinburgh.

What happens next, if I want to take part?

If you are interested in taking part in the evaluation, please tell Sarah that you are happy to continue. You will then be given an informed consent sheet to sign.

Contact information

If, after your participation today, you would like to get in touch with Sarah, or if you have any questions, please feel welcome to contact me by any of the following means:

Miss Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh EH8 9AG
Tel: 0131 650 3043 / Mobile: 07450299054
Email: S.E.Jeavons@sms.ed.ac.uk

If you would like to speak to a staff member at Chalmers about the evaluation, or if you have worries that you wish to raise, please contact:

Dr. Ailsa Gebbie
Consultant Gynaecologist
Chalmers Centre
2A Chalmers Street
EH3 9ES

Tel: 0131 536 1511

Email: Ailsa.Gebbie@nhslothian.scot.nhs.uk

Appendix 15: booked appointment holder invitation letter



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

Date: 02-10-2014

Dear

Participant invitation

My name is Sarah Jeavons and I am a researcher from the University of Edinburgh. I am writing to you to see if you would like to take part in a study about what people **think and feel** about their visit to the IUD/IUS clinic. The documents enclosed here give more details about the study and what taking part would involve.

If you would like to take part, please fill in the 'opt-in' reply slip and return it using the stamped addressed envelope provided. If you are unsure and have questions then please feel free to get in touch for a chat, before you decide if you want to take part. If you don't want to take part, that is fine, you don't have to do anything, you will not be contacted again.

Dr. Ailsa Gebbie, Consultant Gynaecologist at Chalmers, is in support of this study. Dr. Gebbie is available to provide general advice about taking part, or to address any concerns you may have, on the following number: 0131 536 1511.

Thank you for reading this letter and for thinking about taking part in my study.

Yours sincerely,

Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh EH8 9AG
Tel :0131 650 3043/Mobile: 07450299054
Email: S.E. Jeavons@sms.ed.ac.uk

Appendix 16: participant information sheet booked appointment holders



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

My name is Sarah Jeavons and I am a researcher from the University of Edinburgh. I am doing a research study to better understand what people **think and feel** about their visit to Chalmers. Please take the time to read through this information sheet. If you have any questions, or if you would like more information, please contact me. You can also talk to someone who is not part of this project, if you would prefer. All contact information is listed at the end of the information sheet.

What is the purpose of the study?

The purpose of this study is to better understand people's experiences of attending Chalmers. The findings will be used to help improve the services offered at Chalmers.

Why have I been invited?

You have been invited to take part because you are due to attend an appointment at the IUD/IUS clinic at Chalmers. I hope to include about 15 people who attend the IUD/IUS clinic in the study.

What does taking part involve?

If you decide to take part, you would be asked to:

5. Meet me at the clinic on the day of your appointment.
6. Allow me to sit with you as you wait for your appointment with the doctor or nurse.
7. Allow me to come into the consultation room with you (I **would not need to watch any clinical procedures**, only the conversation between you and your doctor or nurse). During the clinical procedures, I will leave the room.
8. Allow me to take notes.

9. Take part in an interview, lasting about 30 minutes, at the end of your time at the clinic, which will be talking about how you felt about your visit. This interview will be audio-recorded. If you do not want the interview to be recorded, I can take notes instead.

Do I have to take part?

No. You **do not** have to take part in the study. If you don't want to take part, that is fine. Your decision will have no impact on your medical care.

Will taking part be confidential?

Yes. Taking part in the study will be anonymous and confidential. This means that:

6. You do not have to tell me your real name. You can sign the documents I give you with a fake name, if you want.
7. The name you give me will never be used in public. I will use a made up ID name instead.
8. All of the information collected when you take part in the study will be kept confidential (private) and will be stored in a locked filing cabinet or on a password-protected computer within a locked office at the University of Edinburgh.
9. The only person with access to this information is me.
10. All the files which relate to the study will be destroyed after completion, probably in the winter of 2015.

What will happen with the findings?

The general findings of this study will be shared with Chalmers management and staff so that they can better understand what it is like for people to come to the IUD/IUS clinic. It will not be possible for staff to know who said what. I expect to publish results in scientific and policy journals and to present findings to health care professionals.

If you would like a summary of the results, I can send these to you in the winter of 2015. You can get this summary by emailing, texting, or phoning me using the contact details below. If you would prefer, you can give me your contact details, and I will send you the results when they are ready.

Are there any benefits to taking part?

There are no direct benefits in taking part in the study, but I hope that you would find the experience interesting. Taking part will help to improve service delivery, and will provide you with the chance to speak at length about your views of the service.

Are there any disadvantages to taking part?

Taking part in the study means that you will need to be at Chalmers for about 30 mins to one hour after your appointment with the doctor or nurse, so that you can take part in the interview. If you cannot stay an extra hour, it will be possible to arrange an interview on another day, at a place and time that you choose.

Who has approved the study?

The study has been reviewed and approved by the Ethics Review Group at the Centre for Population Health Sciences, University of Edinburgh.

What happens next, if I want to take part?

- If you are interested in taking part, please
 - Fill in the 'opt-in' reply slip enclosed and return it to me, using the stamped-addressed envelope provided.
 - If you are happy to provide your contact information on the 'opt-in' reply slip, then I will contact you a day before your appointment to arrange meeting you at Chalmers.
 - If you do not want to give me any contact information, but would still like to take part, then please send the 'opt-in' form back without any contact information and I will meet you in the main waiting area (next to the reception desks) on the day of your appointment. You can contact me if you think you will be late arriving.

Contact details for further information

If you would like to get more information about this study, or if you have any questions, please feel welcome to contact me:

Miss Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place

Edinburgh EH8 9AG
Tel: 0131 650 3043 / Mobile: 07450299054
Email: S.E.Jeavons@sms.ed.ac.uk

If you would like to speak to a staff member at Chalmers about the study to seek general advice about taking part, or have worries that you wish to raise, please contact:

Dr. Ailsa Gebbie
Consultant Gynaecologist
Chalmers Centre
2A Chalmers Street
EH3 9ES
Tel: 0131 536 1511
Email: Ailsa.Gebbie@nhslothian.scot.nhs.uk

Appendix 17: Newsletter bulletin for staff recruitment



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

Sarah Jeavons, from the University of Edinburgh, will be starting her study at Chalmers in January 2014. The study is focused on learning about how attendees and staff experience integration at Chalmers. The research will use inductive methods - observations and interviews – in order to gain in-depth insights into stakeholder experiences.

In January 2014, every member of staff will receive an information pack, which will include an information sheet as well as an informed consent form. Those wishing to take part in the study will be able to return consent forms to dedicated ‘post-boxes’ throughout Chalmers. As this is an ‘opt-in’ study, those not wishing to participate will not need to do anything.

Sarah will be giving a brief introduction to the study at the PLT on December 17th. This will be an opportunity to learn more about the study and what it means to staff at Chalmers. Copies of the information sheet will be provided on the day, so that staff members are able to read through the details of the study and consider participation ahead of the January start date. Sarah will be available to answer any further questions anyone may have following the PLT, via email, phone or in person.

Appendix 18: Information sheet, staff members



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

My name is Sarah Jeavons and I am a researcher from the University of Edinburgh. Having spent some time at Chalmers earlier this year (February and April 2013) I am now about to commence fieldwork on a full-time basis. This is a study concerned with better understanding attendee and staff views of integration. In order to conduct the study, I will spend the coming 10 -12 months at Chalmers.

What is the purpose of the study?

This study hopes to better understand the experiences of those working within, or attending, Chalmers. The findings will be used to help improve the services offered.

Why have I been invited?

You have been invited to participate in the study because you work at Chalmers. A central component of the study involves conducting observations with consenting attendees as they access care. In addition, I may be present during staff meetings or trainings. As you work at Chalmers it is, therefore, important to know whether you consent to participating in these observations or not.

What does consenting to the study involve?

If you consent to take part, this would involve:

1. Allowing me to accompany and observe attendees on their care pathway. This includes sitting in on clinical consultations, although I will not be present during intimate examinations. Observations **are not** about making judgements on staff management of the patient.

2. Agreeing to the possibility of being invited to participate in an interview with me, focused on learning about your experiences, and views, of integration at Chalmers.

Do I have to take part?

No. **This is voluntary.** It is up to you whether you want to take part or not. If you decide not to take part, it will not affect your employment. I will not discuss individual staff member's decisions with anyone.

Will taking part in the study be confidential?

Yes. Taking part in the study will be anonymized and confidential. This means that:

11. Your name will never be linked to what you say, or what I observe, and will never be used in any of the publications which arise from the study. A pseudonym will be allocated.
12. All of the information collected when you take part will be kept confidential and will be stored in a locked filing cabinet or on a password-protected computer within a locked office at the University of Edinburgh.
13. The only person with access to this information is the researcher.
14. All the files which relate to the evaluation will be destroyed within 5 years of the completion of the study. Until this point, Sarah will remain the only person with access to the files.

What will happen with the findings?

The general findings of this study will be shared with Chalmers management and staff to better understand what it is like for people to access care at Chalmers, or to work within the facility. It will not be possible to identify individual participants from the findings. I expect to publish results in scientific and policy journals and to present findings to health care professionals.

Are there any benefits to taking part?

There are no direct benefits in taking part in the study, but I hope that you would find the experience interesting. Taking part will help to improve service delivery, and will provide you with the chance to speak at length about your views of the service.

Are there any disadvantages to taking part?

In the case of observations, you are being asked to allow the researcher to be present in your place of employment. However, in all instances, I will remain as unobtrusive as possible. Regarding the interview, which staff may be invited to participate in, this will mean being asked to give about an hour of your time. The interview, however, should not cover any issues which you will find distressing and they will be designed in order to allow for you to raise any issues you may want to discuss.

Who has approved the study?

The evaluation has been reviewed and approved by the CPHS Ethics Review Group at the University of Edinburgh.

What happens next, if I want to take part?

If you are interested in taking part in the study, please complete the consent form enclosed and: 'post' it into the designated boxes within the facility, or return it to Sarah in person. If you do not wish to participate, there is no need to do anything. If you have any queries please do not hesitate to contact me to discuss the study further, prior to consenting. I will make myself available to discuss any questions you may have in person. I will be available to answer any queries you may have on December 17th at the PLT.

IMPORTANT!

If you do not consent to participating in the study, I will do my best to avoid interacting with you. I will always ask whether a staff member consents to my presence, in addition to collecting consent forms, and so if you would rather I were not present at any time, please just ask me to leave.

Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh EH8 9AG
Tel: 0131 6503043/ Mobile: 07450299054
Email: S.E.Jeavons@sms.ed.ac.uk

Appendix 19: Informed consent, staff members



Integrating sexual health services: A qualitative evaluation of attendee and staff experience.

Participant ID [researcher to complete]

Thank you for reading the information sheet about the study. Please *INITIAL* the boxes if you agree to each statement.

1. I have read and understand the information sheet for the study. ()
2. I was able to ask questions about the study and felt happy with the answers I was given ()
3. I understand that taking part is voluntary and that I am free to withdraw at any time, without giving any reason, and without my employment being affected. ()
4. I understand that the evaluation has been reviewed by the Ethics Review Group at the Centre for Population Health Sciences and has received favourable opinion. ()
5. I understand that I **may** be invited to take part in an interview and I understand that the interview will be audio-recorded and typed up. ()
6. I understand and agree to anonymized quotations from this interview being used in publications. ()

7. I agree to being part of on-going observational research at Chalmers. ()
 I understand that observations will be made while the researcher
 accompanies consenting patients throughout their care pathway
 and **are not concerned** with judging individual job performance.

8. I understand and agree to anonymized notes taken in this study ()
 being used to inform the findings.

9. I understand who will have access to the data provided, ()
 that the data will be stored on a password protected computer
 at the University of Edinburgh, that my details will be fully
 anonymised and that all data will be destroyed at the end of the project

10. I agree to taking part in the above study. ()

Once you have read the above statements and wish to proceed, please fill in the details below:

.....

Name – PLEASE PRINT

.....

Signature

.....

Date

Miss Sarah Jeavons
Centre for Population Health Sciences
University of Edinburgh
Medical School
Teviot Place
Edinburgh EH8 9AG
Tel: 0131 651 7112 / Mobile: 07450 299 054
Email: S.E.Jeavons@sms.ed.ac.uk